FIRSTSIGHT VISION SERVICES, INC.

Enrollment Form

Name _____ DOB _____ Date _____

Address _____

Phone Home: _____ Cell: _____ Email: _____

ENROLLMENT I want to become a Member of FirstSight Vision Services, Inc. under the EYE EXAMINATION BENEFIT.

I have paid/will pay the total exam fee (which includes the applicable co-pay & premium) payable to "FirstSight Vision Services, Inc.," to pay for the exam services provided plus the premium for one year.

Signature X _____

I agree to accept electronic delivery of my Membership Contract, which describes fully my Membership terms. I understand I can obtain that electronic copy at www.firstsightvision.net. If I have questions or want to receive a paper copy, I can call (800) 841-2790. Initials _____