

EZ Optical Savings Plan

Enrollment Application *(Please Print Clearly)*

Company Name: _____

Employee Name: _____

Street Address: _____

City/State/Zip Code: _____

Phone Number: _____

Email Address: _____

Spouse/Partner's Name: _____

Children/Parents: _____

Optical Insurance : Yes No Type: _____

Mail to : **Rochester Optical ▪ Attn: Joe Condidorio ▪
1260 Lyell Ave. ▪ Rochester, NY 14606**

For Office Use Only:

Date: _____ Paid: Cash Check Check # _____

Enrollment Period: _____ *Fee waived per Joe Condidorio*

Membership Number: _____