



PracticePlusSM

PracticePlus Enrollment Application

Contact Name: _____ Date: _____
 Office Name: _____
 Office Street Address: _____
 City: _____ State: _____ Zip: _____
 Office Mailing Address: _____
 City: _____ State: _____ Zip: _____
 Office Phone: () _____ Office Fax: () _____
 Office email: _____

Wholesale Laboratory Suppliers:

1. Name: _____ City: _____ State: _____
 2. Name: _____ City: _____ State: _____
 3. Name: _____ City: _____ State: _____

If individual enrollment, provide income tax information.

Social Security (Canadian Social Insurance) Number: _____

If office enrollment, provide business tax information.

Tax ID (Canadian GST-HST) Number: _____ Incorporated: Yes No
 If 'Yes', Corporation Name: _____
 If 'No', Sole Proprietor Partnership

Do you currently dispense KODAK Lenses? Yes No
 What is your Primary progressive brand now? _____
 What is your Primary high index single vision and flat-top brand? _____
 How many progressives do you dispense on average per week? _____
 How many high index lenses do you dispense on average per week? _____

How did you hear about PracticePlus? _____
 Do you know anyone who would be interested in hearing about PracticePlus or KODAK Lenses? _____
 Name: _____ Office: _____ Phone: _____
 Name: _____ Office: _____ Phone: _____

Complete and fax this form to Signet Armorlite. Fax Number 800 759 0660. OR Mail it to: Signet Armorlite, Attention: PracticePlus, 1001 Armorlite Drive, San Marcos, CA 92069

Questions? Call the PracticePlus Lens Consultants at 800 950 5367



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