ABB Optical Group Affiliation Form

Member Information

Account Name_____

Doctor/Owner Name_____

Address: _____

City_____ State_____ Zip _____

Work Phone _____

Email_____

Account Information

ABB Account Number: _____

Written Notice Consent:

ABB may change a Member's designation of its alliance of choice to another alliance upon receipt of written notification or instructions (including electronic) directly from such Member. ABB shall confirm all changes to a Member's alliance of choice designation directly with such Member.

By completing this form, you are authorizing IOP to submit an affiliation request for ABB Optical Group. Doing so will affiliate the account number above with IOP pricing and benefits.

Signature _____

Title_____

Name_____ Date_____

Please send completed form to: StratSalesSupport@abboptical.com