



--	--

I am Waiving Vision Insurance

**AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM**

**PLEASE PRINT LEGIBLY**

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

Policy No. VC-16

**TO BE COMPLETED BY THE EMPLOYEE**

Employee Last Name		Employee First Name		MI
Date of Birth / /	Social Security Number - -	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Street Address				Apartment No.
City		State	Zip Code -	

Do you wish to cover your eligible dependents?  Yes  No

*If yes, complete the following:*

	Dependent Name	Date of Birth
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

<b>I authorize deductions from my earnings at the required contributions towards the cost of the coverage.</b>	
Signature	Date / /

A-00713

M-9059/M-9069/M-9086

**TO BE COMPLETED BY THE EMPLOYER**

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add ○ Dependents	<input type="checkbox"/> Change ○ Address ○ Name	<input type="checkbox"/> Phone ○ COBRA	<input type="checkbox"/> Cancel Coverage ○ Policy Holder ○ Dependent(s)
Reason for Change	<input type="checkbox"/> Employment Status <input type="checkbox"/> Qualifying Event: (PLEASE STATE) _____			
Requested Effective Date / /	Date of Employment / /			