



Advantage Vision Care

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

Policy No. VC-16/VC-23

Please fax completed form to
Matt Grauwiler: 866-214-3215

EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Employee Name _____ Date of Birth _____
Last First MI

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex Male Female

Employer Group Name _____

Do you wish to cover your eligible Dependents? Yes No

If yes, complete the following:

	Name	Date of Birth		Name	Date of Birth
Spouse	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____

I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Date _____ Signature _____

A-00713

M-9004/M-9059

Group Number _____ Sub-Group (if applicable) _____ Plan Number _____

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add/Change	<input type="checkbox"/> Cancel Coverage
	__ Dependent	__ Name
	__ Address/Phone	__ Cobra
		__ Policy Holder
		__ Dependent(s)

Reason for Change: Employment Status Qualifying Event

Please State Qualifying Event: _____

Member Effective Date: _____ Date of Employment: _____

By signing above, I understand and agree that I must remain enrolled during the Benefit Plan period.