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

Advantage Vision Care

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri
Policy No. VC-16/VC-23

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Date ______________ Signature ______________________________

A-00713KY M-9004/M-9059

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

❒ **New Enrollment**

❒ **Add/Change**
__ Dependent
__ Address/Phone
__ Name
__ Cobra

❒ **Cancel Coverage**
__ 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.