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☐ I am Waiving Vision Insurance

AVĒSIS 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*
/ /	- -	☐ Male ☐ 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)

I agree to receive all documents and correspondence electronically, and I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone. ☐ Yes ☐ No

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.

Signature	*Date*
	/ /

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ◯ Dependents	☐ **Change** ◯ Address ◯ Phone ◯ Name ◯ COBRA	☐ **Cancel Coverage** ◯ Policy Holder ◯ Dependent(s)

Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____

Requested Effective Date / /	*Date of Employment* / /