AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company *Kansas City, Missouri*

Policy No. VC-16/VC-23

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 FIRST	LAST	*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 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.

Signature	*Date* / /

A-00713 M-9004/M-9059

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

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ○ Dependent(s)	☐ **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* / /

06/09