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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/VC-23

**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
	FIRST	LAST
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.

Signature	Date     /     /
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A-00713

M-9059/M-9069/M-9086

**TO BE COMPLETED BY THE EMPLOYER**

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