



A National Vision, Dental and Hearing Company

Empty rectangular box for stamp or signature.

AVESIS 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 <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.
 I certify that I am eligible to participate and that the above information is correct.
 It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature	Date / /
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A-00713VA

M-9059VA

TO BE COMPLETED BY THE EMPLOYER

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