



ADVANTAGE VISION

UNDERWRITTEN BY FIDELITY SECURITY LIFE INSURANCE COMPANY
GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT FORM

(PLEASE PRINT LEGIBLY)

CHANGE [] ADD [] TERM [] Effective Date _____

Group Number _____ Plan Number _____ Division _____

Employer Group Name _____

Date of Employment _____ Plan Effective Date _____

Employee Name Last First M.I. Date of Birth

Address _____ City _____ State _____ Zip _____

Social Security Number _____ MALE [] FEMALE []

Do you wish to cover your eligible Dependents? Yes | | No | | Cancel Coverage

If yes, complete the following:

Names Last First M.I. Date of Birth Last First M.I. Date of Birth

Spouse _____

Child _____

Child _____

I hereby apply for coverage under Avesis, Third Party Administrators, Inc. for which I am now entitled or may become entitled under the provisions of the plan. 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. I agree that once enrolled I will remain enrolled during the designated plan period.

(Date) _____ (Signature) _____