

☐ I decline coverage. \_\_\_\_\_  
Employee signature to decline coverage

## 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<br>/ / | Social Security Number<br>- - |                     | Sex<br><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 |
|--------|----------------|---------------|
| Spouse |                | / /           |
| Child  |                | / /           |
| Child  |                | / /           |
| Child  |                | / /           |
| Child  |                | / /           |
| Child  |                | / /           |
| Child  |                | / /           |

☐ I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that 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.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

|           |          |
|-----------|----------|
| Signature | Date / / |
|-----------|----------|

### TO BE COMPLETED BY THE EMPLOYER

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