



A National Vision and Dental 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/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. I certify that I am eligible to participate and that the above information is correct.

Signature	Date / /
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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

<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) _____	
Requested Effective Date / /		Date of Employment / /	