



A National Vision and Dental Company

## AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

PLEASE PRINT LEGIBLY

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