Avēsis
INCORPORATED

ADVANTAGE VISION CARE

UNDERWRITTEN BY FIDELITY SECURITY LIFE INSURANCE COMPANY

GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

(PLEASE PRINT LEGIBLY)

CHANGE ☐ ADD ☐ TERM ☐ Effective Date ____/____/____

Group Number _____ Plan Number _____ Sub/Group _____

Employer Group: _____

Date of Employment: ____/____/____ Plan Effective Date: ____/____/____

Employee Name: _____ Date of Birth ____/____/____
LAST FIRST M.I.

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	Names: Last	First	M.I.	Date of Birth
Spouse:				Child:			
Child:				Child:			
Child:				Child:			
Child:				Child:			

hereby apply for coverage under Avesis, Third Party Administrators, Inc. for which I am now entitled or may become ntitled under the provisions of the plan. I authorize deductions from my earnings at the required contributions towards he cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I agree that nce enrolled I will remain enrolled during the designated plan period.

Date) _____ (Signature) _____

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Policy Form M-9004
Policy No. VC-16/VC-22/VC-23/VC 44

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