SUPERIOR VISION

# VISION INSURANCE

**Underwritten by National Guardian Life Insurance Company**

**Administered by:**
**Superior Vision Services**
**11101 White Rock Road**
**Rancho Cordova, CA 95670**

## Enrollment / Change Form

Please print and complete all sections.

**GROUP/EMPLOYEE INFORMATION** A: Add (enroll) T: Terminate C: Change (change of name or coverage)

| | | | | |
|---|---|---|---|---|
| Group Name<br>Siloam Springs School District | Group Number<br>32062 | Location | Effective Date | Date of Hire |

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name | First Name | M.I. | Date of Birth | Social Security Number |

| | | | |
|---|---|---|---|
| Home Street Address | City/State/Zip | Home Phone<br>( ) | Work Phone<br>( ) |
| Email Address | | | Cell Phone<br>( ) |

**ELECTION(S)**

| | | | | | |
|---|---|---|---|---|---|
| Employee Only | Employee + Spouse | Employee + Child(ren) | Employee + Family | Waived due to other coverage | Waive |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**FAMILY INFORMATION (Only those eligible may be enrolled.)** A: Add (enroll) T: Terminate C: Change (change of name or coverage)

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (spouse) | First Name | M.I. | Date of Birth | |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | Child unmarried and full-time student or handicapped?<br>☐ Yes ☐ No |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐ Yes ☐ No |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐ Yes ☐ No |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐ Yes ☐ No |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐ Yes ☐ No |
| ☐ A<br>☐ T<br>☐ C | Sex<br>☐ M<br>☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐ Yes ☐ No |

Employee Signature: ______________________________ Date: ______________

**Do you or any of your dependents have other vision insurance?** ☐ Yes ☐ No

If yes, please give: Policyholder ______________ and Insurance Company ________________.

Declination of coverage must be accompanied by the Employee's signature above.

**Fraud Warning Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and may subject such person to criminal and civil penalties.**