Avesis
INCORPORATED

AVESIS VISION CARE
UNDERWRITTEN BY FIDELITY SECURITY LIFE INSURANCE COMPANY
GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT FORM

(PLEASE PRINT LEGIBLY)

CHANGE ☐ **ADD** ☐ **TERM** ☐ **Effective Date** _____

Group Number _____ Plan Number _____ Division _____

Employer Group Name _____

Date of Employment _____ Plan Effective Date _____

Employee Name _____ Date of Birth _____
LAST FIRST MIDDLE INITAL

Address _____ City _____ State ____ Zip ____

Social Security Number _____ MALE ☐ FEMALE ☐

Do you wish to cover your eligible Dependents? Yes ☐ No ☐

If yes, complete the following:

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

I hereby apply for coverage under AVESIS, TPA for which I am now entitled or may become entitled under the provisions of the plan. 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. I agree that once enrolled I will remain enrolled during the designated plan period.

(Date) _____ (Signature) _____

A-00713

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