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**
Spouse:				
Child:				
Child:				
Child:				

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

I hereby apply for coverage under Avesis, Third Party Administrators, Inc. 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

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