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| SuperiorVision_v_k_TM **J:\Signatures\LOGO.BMP*VISION INSURANCE***  Underwritten by National Guardian Life Insurance Company  **Administered by:**  **Superior Vision Services** 11090 White Rock Road Suite 175Rancho Cordova, CA 95670Enrollment / 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 **Mississippi Department of Transportation** | | | | **Group Number**  **35207** | | | Location | | Effective Date | | | | | | | Date of Hire |
| A  T  C | Sex M  F | **Last Name** | | | | First Name | | **M.I.** | | **Date of Birth** | | | Social Security Number | | | |
| Home Street Address | | | City/State/Zip | | | | | Home Phone **(**     **)** | | | | | | **Work Phone**  **(**     **)** | | |
| Email Address | | | | | | | | | | | | Cell Phone **(     )** | | | | |
| **ELECTION(S)**  **Employee Employee + Employee + Employee + Waived due to Waive**  **Only Spouse Children Family other coverage**  **$6.66 $12.00 $12.66 $19.98** | | | | | | | | | | | | | | | | |
| **FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)** | | | | | | | | | | | | | | | | |
| A  T  C | Sex M  F | **Last Name (spouse)** | | | First Name | | | **M.I.** | | | **Date of Birth** | | | |  | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | Child unmarried and full-time student or handicapped?  **Yes** **No** | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | **Yes No** | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | **Yes No** | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | **Yes No** | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | **Yes No** | |
| A  T  C | Sex M  F | **Last Name (dependent)** | | | **First Name** | | | **M.I.** | | | **Date of Birth** | | | | **Yes No** | |

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| Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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. |

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.