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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.