avēsis
a GUARDIAN company

☐ I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Avesis Insurance Incorporated Phoenix, Arizona

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth / /	*Social Security Number* - -	*Sex* ☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code* -

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

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

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.

Signature	*Date* / /

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By signing above, I understand that I must remain enrolled during the Benefit Plan period.

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ◯ Dependents	☐ **Change** ◯ Address ◯ Name ◯ Phone ◯ COBRA	☐ **Cancel Coverage** ◯ Policy Holder ◯ Dependent(s)

Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____

Requested Effective Date / /	*Date of Employment* / /

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