Surency life and health

☐ **53273: Opt 1- Comprehensive (Exam + Materials)**

☐ **43273: Opt 2- Materials Only**

Enrollment/Change Form-VISION

Check One:

☐ New Application for Coverage
☐ Change Authorization
☐ Waiver of Coverage (complete Section (4) ONLY)

Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)

Action	Social Security / ID Number	Group Number	Employer/Group Name (Please do not abbreviate)
☐ Add ☐ Term		53273 & 43273	USD 495 - Ft. Larned

Employee Name (First, Middle Initial, Last)				Male ☐ Female ☐	Single ☐ Married ☐
Home Address	City	State	Zip Code	Birth Date (mm/dd/yy)	
Hire Date (mm/dd/yy)	Effective Date (mm/dd/yy)	Type of Vision Coverage ☐ Single ☐ Family	Vision/Medical Carrier and Address		

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

Action		Effective Date (mm/dd/yy)	**Spouse** Name (First, Middle Initial, Last)	Gender	Birth Date
☐ Add	☐ Term			Male ☐ Female ☐	

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits.

Action		Effective Date (mm/dd/yy)	**Dependent** Name (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date
☐ Add	☐ Term			☐	☐	
☐ Add	☐ Term			☐	☐	
☐ Add	☐ Term			☐	☐	
☐ Add	☐ Term			☐	☐	
☐ Add	☐ Term			☐	☐	

Section 3 SIGNATURE/AUTHORIZATION:

I hereby apply for group vision coverage for which I am eligible and authorize the release of vision records to Surency. I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Employer's Agreement with Surency.

Authorization/Signature for Enrollment/Change(s) _____ Date _____

Section 4 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group vision insurance available to me through my employer, and I have decided that I

☐ **Do not** want vision coverage for myself because:_____.

☐ **Do not** want vision coverage for my spouse and/or my children because:_____.

Authorization/Signature for Waiver of Coverage: _____ Date: _____

Printed-Employee Name: (First, Middle Initial, Last): _____ Social Security #: _____

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Surency reserves the rights to reject such applications.

Section 5 CHANGES: (Please mark all appropriate boxes that apply to change(s) you wish to make and sign section 3 above)

SURENCY MUST BE NOTIFIED OF ALL CHANGES WITHIN 30 DAYS OF EVENT

Date of Event: _____ Name Change: From _____ to _____

☐ Marriage ☐ Divorce ☐ Adoption/Custody of Child ☐ Other _____

Surency Vision is administered by Surency Life & Health Insurance Company in collaboration with EyeMed Vision Care.

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