



Underwritten by: National Guardian Life Insurance Company, Madison, WI
 Administered by: Superior Vision Services, Inc.
 11101 White Rock Road, Suite 150, Rancho Cordova, CA 95670

Vision Plan Enrollment Application

Entire form must be completed. Coverage subject to approval.

I. Check the Appropriate Boxes

NEW ENROLLMENT: Basic Plan Enhanced Plan (if boxes left unchecked, will be enrolled in Basic)
 COVERAGE: Employee Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)
 PREMIUM DEDUCTION: Pre-tax Post-tax (if boxes left unchecked, will be enrolled in Pre-tax)

ADD NEWLY ELIGIBLE DEPENDENT: Spouse (marriage) Child (birth)

DROP INELIGIBLE DEPENDENT: Spouse (divorced) Child (age 26)

TERMINATE COVERAGE AT THE END OF THE YEAR: (coverage ends on December 31)

Important Notice: Your election will be in effect for the calendar year. Mid-year drops are not permissible except in the case of employee termination or should a covered dependent become ineligible. Continuation of coverage under COBRA is available under those circumstances. New enrollments may be limited to Open Enrollment Periods.

II. Employee Information (please print clearly):

Your Name _____, _____, _____
(Last) (First) (Middle Initial)

Social Security Number _____ - _____ - _____ Birth Date ____/____/____ Sex (F or M) _____

Home Street Address _____

City/State/Zip _____ Phone (____) _____ - _____

Do you or any of your dependents have other vision insurance? Yes No
 If yes, please give Policyholder's Name _____ and Insurance Company _____

III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Sex
Spouse	_____	_____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F

Employee Signature _____ Date _____
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TO BE COMPLETED BY THE EMPLOYER:
 Effective Date: _____ Campus: UAMS UALR UAF UAM UAPB UACCB
 Group # 028770 ASMSA CES Other: _____
 Hire/Benefit Eligibility Date: _____

Original: U of A 1st copy: Superior Vision 2nd copy: Employee
 NVI-EnrollUofAR 10/10