Superior Vision
Our Members. Our Mission.

University of Arkansas

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			_____/_____/_____	❑M ❑ F
Child			_____/_____/_____	❑M ❑ F
Child			_____/_____/_____	❑M ❑ F
Child			_____/_____/_____	❑M ❑ F
Child			_____/_____/_____	❑M ❑ 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 finds and confinement in prison.

TO BE COMPLETED BY THE EMPLOYER:
Effective Date: _____
Group # 028770
*Hire/Benefit Eligibility Date:*_____

Campus: ❑UAMS ❑ UALR ❑ UAF ❑UAM ❑UAPB ❑ UACCB
❑ASMSA ❑CES Other: _____

Original: U of A 1st copy: Superior Vision 2nd copy: Employee

NVI-EnrollUofAR 10/10