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

University of Arkansas

# 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

BG 9-16-2010