Avēsis
A National Vision and Dental Company

Advantage Vision Care

Underwritten by Avesis Insurance Incorporated
Phoenix, Arizona

EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Employee Name _____ Date of Birth _____
Last First MI

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex ❒ Male ❒ Female

Employer Group Name _____

Do you wish to cover your eligible Dependents? ❒ Yes ❒ No

If yes, complete the following:

	Name	Date of Birth		Name	Date of Birth
Spouse	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____
Child	_____	_____	Child	_____	_____

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.

Date _____ Signature _____

AIIENRF AII-AVP1

Group Number _____ Sub-Group (if applicable) _____ Plan Number _____

❒ **New Enrollment**

❒ **Add/Change**
__ Dependent __ Name
__ Address/Phone __ Cobra

❒ **Cancel Coverage**
__ Policy Holder
__ Dependent(s)

Reason for Change: ❒ Employment Status ❒ Qualifying Event

Please State Qualifying Event: _____

Member Effective Date: _____ Date of Employment: _____

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