



SUPERIOR VISION

# VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by:  
Superior Vision Services  
11101 White Rock Road, Suite 150  
Rancho Cordova, CA 95670



## Enrollment / Change Form

Please print and complete all sections.

**GROUP/EMPLOYEE INFORMATION**    A: Add (enroll)    T: Terminate    C: Change (change of name or coverage)

Group Name <b>Hays County</b>	Group Number <b>27475</b>	Location	Effective Date	Date of Hire
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name	First Name	M.I.	Date of Birth	Social Security Number
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Home Street Address	City/State/Zip	Home Phone (    )	Work Phone (    )
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Email Address	Cell Phone (    )
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ELECTION(S)					
Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waived due to other coverage	Waive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FAMILY INFORMATION (Only those eligible may be enrolled.)**    A: Add (enroll)    T: Terminate    C: Change (change of name or coverage)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do you or any of your dependents have other vision insurance?     Yes     No

If yes, please give: Policyholder \_\_\_\_\_ and Insurance Company \_\_\_\_\_.

Declination of coverage must be accompanied by the Employee's signature above.

**Warning:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.