SuperiorVision™

Underwritten by: National Guardian Life Insurance Company, Madison, WI
Administered by: Superior Vision Services, Inc.
11090 White Rock Road Suite 175, Rancho Cordova, CA 95670

UofA 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)

I understand that any change I need to make to my vision benefits can only take place within 31 days of a qualify change of status event, in accordance with Section 125 regulations.

___**ADD (check all that apply):** ❑ Spouse ❑ Child

___**DROP (check all that apply):** ❑ Spouse ❑ Child

___**TERMINATE ALL COVERAGE:** ❑

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: ❑ UACCB ❑ PCCUA ❑UAM
❑ UAPTC ❑UAPB ❑ UAFS

Other: _____