



VISION INSURANCE
 Underwritten by National Guardian Life Insurance Company
 Administered by:
 Superior Vision Services
 11090 White Rock Road Suite 175
 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 Yadkin Valley Economic Development District Inc.	Group Number 038898	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 <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Children <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Waived due to other coverage <input type="checkbox"/>	Waive <input type="checkbox"/>
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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	
<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
<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
<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
<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
<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

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.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.