



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

Vision Plan Enrollment Application

Entire form must be completed. Coverage subject to approval.

I. Check the Appropriate Boxes	
NEW ENROLLMENT: 🛛 Basic Plan 🖵 Enhanced Plan (ii	f boxes left unchecked, will be enrolled in Basic)
COVERAGE: Concern Coverage Cov	Employee & Child(ren) Employee, Spouse & Child(ren) benefits can only take place within 31 days of a qualify gulations.
ADD (check all that apply): Spouse Child DROP (check all that apply): Spouse Child TERMINATE ALL COVERAGE: Image: Child	
II. Employee Information (please print clearly):	
Your Name,,,,, (Last)	st) (Middle Initial)
Social Security Number Birth Da	te/ Sex (F or M)
Home Street Address	
City/State/Zip	Phone ()
Do you or any of your dependents have other vision insurance? If yes, please give Policyholder's Name	Yes D No
	and Insurance Company
	and Insurance Company
III. List All Eligible Family Members Below (if ele First Name Last Name	and Insurance Company
III. List All Eligible Family Members Below (if ele	and Insurance Company ecting dependent coverage):
III. List All Eligible Family Members Below (if ele First Name Last Name	and Insurance Company ecting dependent coverage): Birth Date Sex
III. List All Eligible Family Members Below (if ele First Name Last Name Spouse	and Insurance Company ecting dependent coverage): Birth Date Sex//
III. List All Eligible Family Members Below (if ele First Name Last Name Spouse	and Insurance Company ecting dependent coverage): Birth Date Sex // M G F // M F
III. List All Eligible Family Members Below (if ele First Name Spouse	and Insurance Company ecting dependent coverage): Birth Date Sex // □M F // □M F // □M F // □M F
III. List All Eligible Family Members Below (if ele First Name Last Name Spouse	and Insurance Company ecting dependent coverage): Birth Date Sex // M G F // M F // M F // M F / M F / M F / M F / M F / M F / M F
III. List All Eligible Family Members Below (if ele First Name Last Name Spouse	and Insurance Company ecting dependent coverage): Birth Date Sex // M G F // M F // M F // M F / M F / M F / M F / M F / M F / M F

Other: