



SUPERIOR VISION

# VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by:

Superior Vision of New Jersey, Inc.

11101 White Rock Road

Rancho Cordova, CA 95670



## Enrollment / Change Form

Please print and complete all sections.

<b>GROUP/EMPLOYEE INFORMATION</b> A: Add (enroll)    T: Terminate    C: Change (change of name or coverage)						
Group Name <b>Atlantic City Board of Education</b>		Group Number <b>308790</b>	Location	Effective Date	Date of Hire	
<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
Home Street Address		City/State/Zip		Home Phone (    )		Work Phone (    )
Email Address					Cell Phone (    )	

### ELECTION(S)

<b>Employee Only</b>	<b>Employee + Spouse</b>	<b>Employee + Child(ren)</b>	<b>Employee + Family</b>	<b>Waived due to other coverage</b>	<b>Waive</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>FAMILY INFORMATION (Only those eligible may be enrolled.)</b> 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 INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.