Enrollment/Change Form

VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by: ExcelVision

P.O. Box 52718, Phoenix, Arizona 85072

Please print and complete all sections.

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

Policyholder Name	Group Number	Location	Effective Date	Date of Hire

☐ A ☐ T ☐ C	Sex ☐ M ☐ 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
	( )

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

	Sex	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? ☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No

NOTE for Vision: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.

Employee Signature: ______________________________ Date: ________________

I elect the following Vision Coverage(s):

- ☐ Employee Only ________
- ☐ Employee + Spouse ________
- ☐ Employee + Child(ren) ________
- ☐ Employee + Family ________
- ☐ Waived due to other coverage
- ☐ Waive

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

If yes, please give: Policyholder____________________ and Insurance Company ______________________

Is this Policy replacing an existing Policy? ☐ **Yes** ☐ **No** **If Yes, provide name of Policy being replaced:** _______________

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.