Surency VISION

# Enrollment/ Change Form

**Check One:** ☐ New Application ☐ Change Authorization ☐ Waiver of Coverage (complete Section 4 ONLY)

## Section 1 - Employee Information

**Action**

☐ Add ☐ Term

Social Security/ID # _____ Group # _____ Employer/Group Name (Please do not abbreviate) _____

Employee Name (First, Middle Initial, Last) _____

☐ Male ☐ Female ☐ Single ☐ Married

Home Address _____ City _____ State _____ ZIP _____ Birth Date (mm/dd/yy) _____

Email Address _____

Hire Date (mm/dd/yyyy) _____ Effective Date (mm/dd/yyyy) _____ Type of Vision Coverage ☐ Single ☐ Family Vision/Medical Carrier and Address _____

## Section 2 - Dependent Information (List ONLY eligible family members to be enrolled or affected by change)

**Action**

☐ Add ☐ Term

**Effective Date (mm/dd/yy)** _____ **Spouse Name (First, MI, Last)** _____ ☐ Male ☐ Female **Birth Date** _____

**NOTE:** If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits.

| Action | Effective Date (mm/dd/yy) | Dependent Name (First, MI, Last if different) | Gender | Birth Date |
|---|---|---|---|---|
| ☐ Add ☐ Term | | | ☐ Male ☐ Female | |
| ☐ Add ☐ Term | | | ☐ Male ☐ Female | |
| ☐ Add ☐ Term | | | ☐ Male ☐ Female | |

## Section 3 - Signature

I hereby apply for group vision coverage for which I am eligible and authorize the release of vision records to Surency. I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Employer's Agreement with Surency.

Signature for Enrollment/Change(s) _____ Date _____

## Section 4 - Waiver of Coverage

**Complete ONLY if you or your family are not enrolling for benefits.**

This is to certify that I have been given the opportunity to apply for group vision insurance available to me through my employer, and I have decided that I:

☐ **Do not** want vision coverage for myself because: _____

☐ **Do not** want vision coverage for spouse and/or my children because: _____

Authorization/Signature for Waiver of Coverage: _____ Date: _____

Employee Name: (First, Middle Initial, Last): _____ SS #: _____
(Please Print)

**Waiver of Coverage**

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Surency reserves the rights to reject such applications.

## Section 5 - Changes

**Please mark all appropriate boxes that apply to change(s) you wish to make and sign Section 3 above. Surency must be notified of all changes within 30 days of the qualifying event.**

Date of Event: _____ Name Change: From _____ to _____

☐ Marriage ☐ Divorce ☐ Adoption/Custody of Child ☐ Other: _____

**Return completed form back to Surency at email: eligibility@surency.com - fax: 316-462-3394**
**or mail: P.O. Box 789773, Wichita, KS 67278-9773**
**866-818-8805 • Surency.com**