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): ____________ (Please Print) SS #: ____________

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

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