



# Advantage Vision Care

Underwritten by Fidelity Security Life Insurance Company  
Kansas City, Missouri

Policy No. VC-16/VC-23

## EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex  Male  Female

Employer Group Name State of Iowa Employees

Do you wish to cover your eligible Dependents?  Yes  No

### If yes, complete the following:

Name	Date of Birth	Name	Date of Birth
Spouse _____	_____	Child _____	_____
Child _____	_____	Child _____	_____
Child _____	_____	Child _____	_____
Child _____	_____	Child _____	_____

I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Date \_\_\_\_\_ Signature \_\_\_\_\_

A-00713

M-9004/M-9059

<b>THESE FIELDS MUST BE COMPLETED:</b>	Employee Phone Number: _____
Dept Number: _____ Dept Name: _____	Position: _____

Group Number 60790-1232 Sub-Group (if applicable) \_\_\_\_\_ Plan Number 963NC

**New Enrollment**       **Add/Change**       **Cancel Coverage**

    \_\_\_ Dependent      \_\_\_ Name      \_\_\_ Policy Holder

    \_\_\_ Address/Phone      \_\_\_ Cobra      \_\_\_ Dependent(s)

<b>RATES:</b>	
EO	<b>\$9.98</b>
E + 1	<b>\$18.96</b>
E + CH	<b>\$20.66</b>
E + F	<b>\$26.56</b>

Reason for Change:  Employment Status       Qualifying Event

Please State Qualifying Event: \_\_\_\_\_

Member Effective Date: \_\_\_\_\_ Date of Employment: \_\_\_\_\_

<b>Send Form or Fax to:</b>	Two Rivers Insurance Services 214 N. Main Street P.O. Box 746 Burlington, IA 52601 Fax: 319-758-8521
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By signing above, I understand and agree that I must remain enrolled during the Benefit Plan period.