



SUPERIOR VISION

VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by:

Superior Vision Services

11101 White Rock Road, Suite 150

Rancho Cordova, CA 95670



Return form to : Gallagher Affinity

P.O. Box 4111

Clinton, IA 52733

Enrollment / Change Form

Please print and complete all sections.

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

Group Name Pennsylvania Institute of Certified Public Accountants		Group Number 308830	Location	Effective Date	Date of Hire
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<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
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Home Street Address	City/State/Zip	Home Phone ()	Work Phone ()
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Email Address	Cell Phone ()
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ELECTION(S)

Employee Only <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Waived due to other coverage <input type="checkbox"/>	Waive <input type="checkbox"/>
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FAMILY INFORMATION (Only those eligible may be enrolled.) 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/SSN	
<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/SSN	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/SSN	<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/SSN	<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/SSN	<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/SSN	<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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.