VISION INSURANCE ENROLLMENT FORM

EMPLOYEE INFORMATION (To be completed by employee)

Social Security # _____ Date of Birth _____

First Name _____ MI ___ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Job Title _____

TYPES OF COVERAGE (To be completed by employee)

Employee Only ☐

Employee & One Dependent ☐

Employee & Family ☐

Decline Coverage ☐

DEPENDENT INFORMATION (To be completed by employee)

First Name	MI	Last Name	Sex	Date of Birth	Relationship	SS #

_____ _____

Signature Date

EMPLOYER INFORMATION (For Employer use only)

Company Name Superior Effective Date _____

Policy Number _____ Hire Date _____

Authorization Signature _____ Enrollment Date _____