Superior Vision®
Our Members. Our Mission.

UofA
University of Arkansas

Underwritten by: National Guardian Life Insurance Company, Madison, WI
Administered by: Superior Vision Services, Inc.
11101 White Rock Road, Suite 150, Rancho Cordova, CA 95670

Vision Plan Enrollment Application

Entire form must be completed. Coverage subject to approval.

I. Check the Appropriate Box

NEW ENROLLMENT: ❑ Employee ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)
PLAN OPTION: ❑ Basic Plan ❑ Enhanced Plan (if boxes left unchecked, will be enrolled in Basic Plan)
Premium Deduction: ❑ Pre-tax ❑ Post-tax

DROP INELIGIBLE DEPENDENT: ❑ Spouse (divorced) ❑ Child (no longer a full-time student and/or age 25)

TERMINATE COVERAGE: ❑

Important Notice: Your election and pre-tax premium deduction will be in effect for the calendar year. Mid-year changes or drops are not permissible except in the case of employee termination or should a covered dependent become ineligible. Continuation of coverage under COBRA is available under those circumstances. New enrollments and changes are limited to Open Enrollment Periods.

II. Employee Information (please print clearly):

Your Name _____, _____ _____
(Last) (First) (Middle Initial)

Social Security Number _____ - _____ - _____ Birth Date ____/____/____ Sex (F or M) _____

Home Street Address_____

City/State/Zip_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Do you or any of your dependents have other vision insurance? ❑Yes ❑ No.
If yes, please give Policyholder's Name_____ and Insurance Company_____

III. List All Eligible Family Members Below (if electing or terminating dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Add	Term
Spouse			____/____/____	not applicable	❑	❑
Child			____/____/____	❑Yes ❑ No	❑	❑
Child			____/____/____	❑Yes ❑ No	❑	❑
Child			____/____/____	❑Yes ❑ No	❑	❑
Child			____/____/____	❑Yes ❑ No	❑	❑

Employee Signature_____ Date_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TO BE COMPLETED BY THE EMPLOYER:
Effective Date: _____
Group # 028770
Hire/Benefit Eligibility Date:_____

Campus: ❑UAMS ❑ UALR ❑ UAF ❑UAM ❑UAPB ❑ UACCB
❑ASMSA ❑CES Other: _____

NVI-EnrollUofAR 09/09

Original: U of A 1st copy: Superior Vision 2nd copy: Employee