

Enrollment/Change Form
VISION INSURANCE

Underwritten by National Guardian Life Insurance Company
Administered by: Block Vision, Inc. P.O.Box 14035, Milwaukee, WI 53214



Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
Group Name PICPA		Group Number 308830	Location	Effective Date	Date of Hire
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone ()		Work Phone ()
Email Address					Cell Phone ()

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Signature: _____ Date: _____

I elect the following coverage(s):

Employee Only \$ _____

Employee + 1 \$ _____

Employee + Family \$ _____

Waived due to other coverage

Waive

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 subjects such person to criminal and civil penalties.