Superior Vision™

**SUPERIOR VISION OF TEXAS**
**11090 White Rock Road Suite 175**
**Rancho Cordova, CA 95670**
**Phone: (800) 507-3800 Fax: (800) 469-3888**

# Enrollment / Change Form

**Please print and complete all sections.**

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

| Group Name | Group Number | Location | Effective Date | Date of Hire |
|---|---|---|---|---|
| Guadalupe County | 322600 | | | |

| ☐ A ☐ T ☐ C | Sex ☐ M ☐ 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 |
|---|---|
| | ( ) |

**ELECTION(S)**

| Employee Only | Employee + Spouse | Employee + Child(ren) | Employee + Family | Waived due to other coverage | Waive |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Plan Type:** ☐**Full Service (exam and materials)**

**FAMILY INFORMATION** **(Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (spouse) | First Name | M.I. | Date of Birth | |
|---|---|---|---|---|---|---|
| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | Child unmarried and full-time student or handicapped? ☐Yes ☐No |
| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐Yes ☐No |
| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐Yes ☐No |
| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐Yes ☐No |
| ☐ A ☐ T ☐ C | Sex ☐ M ☐ F | Last Name (dependent) | First Name | M.I. | Date of Birth | ☐Yes ☐No |

Employee Signature: _____ Date: _____

By signing above, you agree to receive plan documents, information, and notices electronically.

**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.

I am aware of and accept the following coverage conditions:
1. I (we) authorize the use of my (our) medical records for the quality assurance program conducted by Superior Vision of Texas or its designees, as permitted by law. A copy of this authorization will be valid as the original.
2. I (we) will abide by the terms of the contract in which I (we) enrolled.
3. I (we) will cooperate as required by the Coordination of Benefits procedures.