Superior Vision Change Form

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

Employee Benefits
VISION INSURANCE

Change Form

Please print and complete all sections. See instructions below.

Superior Vision
Our Members. Our Mission.

EMPLOYER/EMPLOYEE INFORMATION

☐ A: Add (enroll) ☐ T: Terminate ☐ C: Change (change of name or coverage)

Employer Name	Group Number	Location	Effective Date	Date of Hire
Davie County Schools	*27579*			

Sex	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
☐ M ☐ F					

Home Street Address	City/State/Zip	Home Phone	Work Phone
		( )	( )

FAMILY INFORMATION (Only those eligible may be enrolled.)

☐ A: Add (enroll) ☐ T: Terminate ☐ C: Change (change of name or coverage)

Sex	Last Name (spouse)	First Name	M.I.	Date of Birth
☐ M ☐ F				
☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth

I elect the following coverage(s):

☐ **Vision**
- ☐ EE $_____
- ☐ ED $_____
- ☐ EF $_____
- ☐ Waived

Declination of coverage must be accompanied by the employee's signature below.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Do you or any of your dependents have other vision insurance? ☐ Yes ☐ No

If yes, please give: Policyholder _____ and Insurance Company _____

Employee Signature: _____ Date: _____