Enrollment Form

Items marked * are required. Complete form using **Blue** or **Black** ink only. **If you send this form via email, please send via secure email to protect PHI to ensure compliance with HIPAA. You may request a secure link from membersupport@usavision.net** or send by FAX to **888.959.4393**. Failure to complete this form correctly may result in delayed enrollment and/or a later Coverage Start Date.

Group

Group Name*

Subgroup (if applicable)

Member

SSN* ___ - __ - ____

Coverage Start Date* __ / 01 / 20 __

Name*

Date of Birth* __ / __ / ____

Gender*

Phone ___ - ___ - ____

Spouse (only complete if the Spouse will be covered)

Name*

Date of Birth* __ / __ / ____

Gender*

Children (only complete if a Child will be covered)

Name*

Date of Birth* __ / __ / ____

Gender*

Name*

Date of Birth* __ / __ / ____

Gender*

Name*

Date of Birth* __ / __ / ____

Gender*

Name*

Date of Birth* __ / __ / ____

Gender*

Acknowledgement

I hereby request coverage as outlined above under USAvision plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with my employers policy provisions. I declare all answers are true and complete. **WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signature*

Date* __ / __ / ____