



**Check One:**  
 **Comprehensive (Exam + Materials)**  
 **Materials Only**

# Enrollment/Change Form-VISION

**Check One:**  
 New Application for Coverage  
 Change Authorization  
 Waiver of Coverage (complete Section (4) ONLY)

**Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)**

Action <input type="checkbox"/> Add <input type="checkbox"/> Term	Social Security / ID Number	Group Number	Employer/Group Name (Please do not abbreviate) <b>U S D #262 - VALLEY CENTER</b>
Employee Name (First, Middle Initial, Last)			Male <input type="checkbox"/> Single <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/>
Home Address	City	State	Zip Code
Hire Date (mm/dd/yy)	Effective Date (mm/dd/yy)	Type of Vision Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Vision/Medical Carrier and Address

**Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)**

Action	Effective Date (mm/dd/yy)	Spouse Name (First, Middle Initial, Last)	Gender	Birth Date
<input type="checkbox"/> Add <input type="checkbox"/> Term			Male <input type="checkbox"/> Female <input type="checkbox"/>	
NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits.				
Action	Effective Date (mm/dd/yy)	Dependent Name (First, Middle Initial) (Last Name, if different)	Male Female	Birth Date
<input type="checkbox"/> Add <input type="checkbox"/> Term			<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Term			<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Term			<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Term			<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Term			<input type="checkbox"/> <input type="checkbox"/>	

**Section 3 SIGNATURE/AUTHORIZATION:**

I hereby apply for group vision coverage for which I am eligible and authorize the release of vision records to Surency. I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Employer's Agreement with Surency.

\_\_\_\_\_  
 Authorization/Signature for Enrollment/Change(s) Date

**Section 4 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)**

This is to certify that I have been given the opportunity to apply for group vision insurance available to me through my employer, and I have decided that I

**Do not** want vision coverage for myself because: \_\_\_\_\_

**Do not** want vision coverage for my spouse and/or my children because: \_\_\_\_\_

Authorization/Signature for Waiver of Coverage: \_\_\_\_\_ Date: \_\_\_\_\_

**Printed**-Employee Name: (First, Middle Initial, Last): \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Waiver of Coverage**  
 I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Surency reserves the rights to reject such applications.

**Section 5 CHANGES: (Please mark all appropriate boxes that apply to change(s) you wish to make and sign section 3 above)**

SURENCY MUST BE NOTIFIED OF ALL CHANGES WITHIN 30 DAYS OF EVENT

Date of Event: \_\_\_\_\_ Name Change: From \_\_\_\_\_ to \_\_\_\_\_

Marriage  Divorce  Adoption/Custody of Child  Other \_\_\_\_\_

Surency Vision is administered by Surency Life & Health Insurance Company in collaboration with EyeMed Vision Care.

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