



**FIDELITY SECURITY LIFE INSURANCE**

**ELECTION OF CONTINUED EMPLOYEE VISION INSURANCE**

**NOTE:** Vision Insurance may be continued subject to COBRA guidelines and state continuance laws.

**TO BE COMPLETED BY EMPLOYER**

Employer's Name \_\_\_\_\_ Group # \_\_\_\_\_ Account # \_\_\_\_\_

Name(s) of Employee and Dependent(s) eligible for contribution \_\_\_\_\_

\_\_\_\_\_

Employee's Social Security # \_\_\_\_\_ Date eligible for continuation \_\_\_\_\_

Date and reason insurance is terminating \_\_\_\_\_

Cost of insurance per month on date eligible for continuation: Employee \$ \_\_\_\_\_ Dependent(s) \$ \_\_\_\_\_

**NOTE:** Premiums are subject to change for continuing insureds for the same reasons as premiums may change for active employee insureds.

Authorized Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE APPLICANT FOR CONTINUED INSURANCE:**

- Please check one:
- I do not wish to continue my vision coverage. I understand that my insurance under this policy will cease as of the date eligible for continuation listed above.
  - I do wish to continue my vision insurance coverage. I understand that timely payment of the premium to the employer is required to keep the insurance in force. I am enclosing with this form my first premium payment, made payable to the employer.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

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