

FOR EMPLOYER / HR USE ONLY GROUP # _____ Hire Date _____ Effective Date _____
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**FIDELITY SECURITY LIFE INSURANCE COMPANY** Kansas City, Missouri  
**OPTICARE VISION PLANS** Rocky Mount, North Carolina  
Vision Care Plan Enrollment Form

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-mail address: (Optional) \_\_\_\_\_

Employer Name: \_\_\_\_\_

Dependent Information:

Name	Date of Birth	Relationship
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group vision coverage for which I am or may become eligible
- If health care is provided by a participating provider, all benefits will be paid directly to the provider by Opticare Vision Plans
- I authorize the release of records or other information pertaining to the vision care services provided to me and my dependents covered on this form by OptiCare Vision Plans providers or other vision providers for the purpose of providing administrative services with OptiCare Vision Plans.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_