FOR EMPLOYER / HR USE ONLY
GROUP # ____________________
Hire Date ____________________
Effective Date ________________

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.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature: ______________________________________ Date: ____________________

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