

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 _____ | _____ | _____ |

- | | |
|--|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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: _____

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