

FIDELITY SECURITY LIFE INSURANCE COMPANY
Kansas City, Missouri

Vision Care Plan
Employee Enrollment Form

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Date of Birth: _____

Employer Name: _____

Dependent Information:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

[I AUTHORIZE my employer to deduct my contribution for insurance premium from my wages or salary.]

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[Employee
Signature: _____ Date: _____]