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.]

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

[Employee
Signature: ______________________________ Date: ________________]