

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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Employee
Signature: _____ Date: _____]