Advantage Vision Care

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

Policy No. VC-16/VC-23

2017 OPEN CHANGE PERIOD FORM

PLEASE PRINT LEGIBLY

Employee Name ______________________________ Date of Birth ______________

Last First MI

Address ______________________ City ______________ State _______ Zip __________

University ID Number ______________________ Sex ☐ Male ☐ Female

Employer Group Name Iowa State University

Do you wish to cover your eligible Dependents? ☐ Yes ☐ No

If yes, complete the following:

	Name	Date of Birth		Name	Date of Birth
Spouse			Child		
Child			Child		
Child			Child		

Monthly Premium: **Employee - $7.33** **Employee + Spouse - $ 13.82**
Employee + Child(ren) - $ 15.13 **Family - $19.46**

I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Date ________________ Signature ______________________________

A-00713 *M-9004/M-9059*

☐ I'd like to **WAIVE** vision coverage at this time. I understand that I will have to wait until the next open enrollment to receive vision benefits. Signature ______________________________

Group Number 607901227 Sub-Group (if applicable) ______________ Plan Number __________

☐ **New Enrollment** ☐ **Add/Change** ☐ **Cancel Coverage**

__Dependent __Name __Policy Holder

__Address/Phone __Cobra __Dependent(s)

Reason for Change: ☐ Open Enrollment ☐ Qualifying Event

Please State Qualifying Event: ______________________________

Member Effective Date: ______________________ Date of Employment ______________________

By signing above, I understand and agree that I must remain enrolled during the Benefit Plan period.