Vision Care

Enrollment Form for Group Vision Coverage

Print or Type

Employer (Group) Name ______________________________

Group No./ Division/ Class ______________________________

Applicant's Full Name ______________________________ Social Security Number _ _ _ - _ _ - _ _ _ _

Address ______________________________

City ______________________________ State __________ Zip Code ______________

Date of Birth _____ / _____ / _______ (mm / dd / yr)   Scheduled hours per week ________________

First day of full-time employment with current employer _____ / _____ / _______ (mm / dd / yr)

☐ Active ☐ Retiree

☐ Male ☐ Female

Vision Coverage Requested

(Select Coverage Option)

☐ Employees Only ☐ Employee and Family

☐ Employee and Spouse ☐ Employee and Child(ren)

Complete the following for all family members for whom you are requesting coverage

Name	Student (Yes/No)	Gender (M/F)	Date of Birth (mm/dd/yr)

☐ I want to be insured, I acknowledge that I have read, understand and agree to the terms and conditions of this coverage as detailed in the brochure and I authorize premium deductions from my pay for the insurance applied for. I understand that I can only make changes to the insurance applied for if I have a family or work status change.

☐ I do not wish to enroll at this time.

Signature ______________________________ _____ / _____ / _______ (mm / dd / yr)

Insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY; American International Life Assurance Company of New York, with its principal place of business in New York, NY; and AIG Life Insurance Company (AIG Life), with its principal place of business in Wilmington, DE. AIG Life does not solicit business in New York.

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