

LINDSEY WILSON COLLEGE AVESIS CHANGE FORM FOR PLAN YEAR 2024

I hereby elect the following vision plan for the 2024 plan year.

<input type="checkbox"/>	Single Low Option MO	\$6.75
<input type="checkbox"/>	Single High Option MO	\$7.95
<input type="checkbox"/>	Family Low Option MO	\$17.56
<input type="checkbox"/>	Family High Option MO	\$21.22
<input type="checkbox"/>	EE + Spouse Low Option MO	\$11.82
<input type="checkbox"/>	EE + Spouse High Option MO	\$14.40
<input type="checkbox"/>	EE + Child(ren) Low Option MO	\$12.83
<input type="checkbox"/>	EE + Child(ren) Plan 2 MO	\$15.67

<input type="checkbox"/>	Single Low Option BW	\$3.38
<input type="checkbox"/>	Single High Option BW	\$3.98
<input type="checkbox"/>	Family Low Option BW	\$8.78
<input type="checkbox"/>	Family High Option BW	\$10.61
<input type="checkbox"/>	EE + Spouse Low Option BW	\$5.91
<input type="checkbox"/>	EE + Spouse High Option BW	\$7.20
<input type="checkbox"/>	EE + Child(ren) Low Option BW	\$6.42
<input type="checkbox"/>	EE + Child(ren) High Option BW	\$7.89

I waive participation in the 2024 vision insurance plan year.

Print Name

Employee L#

Signature

Date



LINDSEY WILSON COLLEGE
30790-1648



HIGH OPTION

LOW OPTION

AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name		Employee First Name		MI
Date of Birth	Social Security Number		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address				Apartment No.
City		State	Zip Code	

Do you wish to cover your eligible dependents? Yes No

If yes, complete the following:

	Dependent Name	Date of Birth
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

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.

Signature	Date
-----------	------

A-00713KY(4/04)

M-9059

TO BE COMPLETED BY THE EMPLOYER

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Change Address <input type="checkbox"/> Name	<input type="checkbox"/> Phone <input type="checkbox"/> COBRA	<input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Policy Holder <input type="checkbox"/> Dependent(s)
Reason for Change		Employment Status Qualifying Event: (PLEASE STATE) _____		
Requested Effective Date		Date of Employment		