LINDSEY WILSON COLLEGE
AVESIS CHANGE FORM
FOR PLAN YEAR 2024

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

☐	Single Low Option MO	$6.75
☐	Single High Option MO	$7.95
☐	Family Low Option MO	$17.56
☐	Family High Option MO	$21.22
☐	EE + Spouse Low Option MO	$11.82
☐	EE + Spouse High Option MO	$14.40
☐	EE + Child(ren) Low Option MO	$12.83
☐	EE + Child(ren) Plan 2 MO	$15.67

☐	Single Low Option BW	$3.38
☐	Single High Option BW	$3.98
☐	Family Low Option BW	$8.78
☐	Family High Option BW	$10.61
☐	EE + Spouse Low Option BW	$5.91
☐	EE + Spouse High Option BW	$7.20
☐	EE + Child(ren) Low Option BW	$6.42
☐	EE + Child(ren) High Option BW	$7.89

☐ I waive participation in the 2024 vision insurance plan year.

_____ _____

Print Name Employee L#

_____ _____

Signature Date

avēsis
a GUARDIAN company

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* ☐ Male ☐ 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

☐ **New Enrollment**	**Add** ☐ Dependents	**Change** ☐ Address ☐ Name ☐ Phone ☐ COBRA	**Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)

Reason for Change	Employment Status Qualifying Event: (PLEASE STATE) _____

Requested Effective Date / /	*Date of Employment* / /

11/17 REV02