MES Vision

CHARTIS

Vision Care

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 t 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.

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