



## University of Central Arkansas Vision Enrollment Form

**Please complete the following information:**

Social Security No.	Last Name	First	MI	Date of Birth / /
Home Address		Home Phone ( )		Sex M <input type="checkbox"/> F <input type="checkbox"/>
City	State	ZIP Code	Business Phone ( )	

**List All Your Eligible Dependents That Are To Be Covered**

First	MI	Last	Sex	Birth Date
Spouse:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /

Effective Date:	Plan Code <b>VISION</b>	Group Number <b>VS4949</b>	Your E-mail Address	Agent Number <b>0503103AR</b>
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PLEASE CHECK YOUR CHOICE	VISION PLAN
Monthly Rates	
Employee Only	<input type="checkbox"/> \$ 8.87
Employee + One	<input type="checkbox"/> \$12.79
Employee + Family	<input type="checkbox"/> \$22.93

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_