

**The Association Insurance Benefit Trust
Vision Program by Superior Vision Services**

Administered by Beneficial Administration LLC
2505 McCabe Way, Irvine, CA 92614
Phone: 1-800-854-7417 • Fax: (949) 724-1603



Employee Enrollment Form

Check appropriate action: New Enrollment Enrollment Change

Employer Group Name: _____

Employee First Name: _____ M.I.: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____

Residential Address: _____

Residential City/State/Zipcode: _____

Residential Telephone: _____

Email Address: _____

Work Telephone/Fax: _____ / _____

Vision Plan Option Selected: High Option Mid Option
 Low Option Materials Only

Type of Coverage Selected: Employee Only Employee & Spouse/Dom.Partner
 Employee & Child Employee & Family

*I understand that such coverage will not go into effect until approved by my employer and accepted by the administrator of the plan.
The following dependents shall be enrolled for coverage:*

Who:	First Name	MI	Last Name:	Soc.Sec.No.	Date/Birth:	Gender:
Spouse/DP:	_____	_____	_____	_____	_____/_____/_____	_____
Child #1:	_____	_____	_____	_____	_____/_____/_____	_____
Child #2:	_____	_____	_____	_____	_____/_____/_____	_____
Child #3:	_____	_____	_____	_____	_____/_____/_____	_____
Child #4:	_____	_____	_____	_____	_____/_____/_____	_____
Child #5:	_____	_____	_____	_____	_____/_____/_____	_____

I hereby authorize my employer to make any necessary deductions from my paycheck to collect my portion of any cost of coverage for which I may be responsible. I understand that my enrollment in the vision plan, while voluntary, requires that **I remain enrolled through the next plan enrollment period which may be as long as twelve months from the date of my signature below.**

Employee Signature: _____ Dated: _____

For administrative use only:

Group No. : _____ Hire Date: _____ Effective Date: _____