

INDIVIDUAL APPLICATION
FOR VISION COVERAGE
(Please Print or Type)



NATIONAL VISION ADMINISTRATORS .LLC

Employer (Group) Name		Group No./Division / Class		
Applicant's Last Name	First	Middle Initial	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number		Date of Birth: (Mo/Day/Year)		
Street Address	City	State	Zip	
First Day Worked Full Time	Date of Re-Call or Return from Leave		Scheduled Hours Per Week	
VISION COVERAGE TYPE REQUESTED				
<input type="checkbox"/> Single <input type="checkbox"/> Limited Family <input type="checkbox"/> Family <input type="checkbox"/> I do not wish to have vision coverage at this time.				

COVERAGE EFFECTIVE DATE: _____

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

LAST NAME	FIRST	INITIAL	STUDENT (Yes / No)	M / F	DATE OF BIRTH Mo/Day/Year
Spouse					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

SIGNATURE: **X** _____ DATE: _____

PLEASE NOTE THAT ONCE YOU WAIVE COVERAGE, YOU WILL NOT BE ALLOWED TO ENROLL UNTIL THE NEXT ENROLLMENT PERIOD. BY ENROLLING DURING THIS ENROLLMENT PERIOD, YOU AGREE TO REMAIN IN THE PLAN UNTIL THE NEXT ENROLLMENT PERIOD. AN EXCEPTION TO THESE UNDERWRITING RULES WOULD BE THE OCCURRENCE OF A QUALIFYING LIFE EVENT, SUCH AS, MARRIAGE, DIVORCE, BIRTH, ETC.

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