SuperiorVision™ ENROLLMENT/CHANGE FORM

COVERAGE INFORMATION:

Name of Employer/Plan Sponsor: Lansing Community College **Group Number:**	**Reason for enrollment or change:** ☐ Initial Enrollment Following Hire ☐ Open Enrollment ☐ Cancel Coverage ☐ Status Change:_____ ☐ Other:_____
Effective date of enrollment or change:	

EMPLOYEE INFORMATION:

Name (Last, First, MI):	**Home Street Address:**
Gender: ☐ Female ☐ Male	**City:** **State:**
Birth Date (MM/DD/YYYY): **Age:**	**ZIP Code:**
Social Security Number:	**Telephone (home/cell):**
Date of Hire:	**Full-time or Part-time Employee:** ☐ Full-time ☐ Part-time

DEPENDENT INFORMATION:

Add/Remove /Change	**Relationship** (to employee)	**Name** (Last, First, MI)	**Birth Date** (MM/DD/YYYY)	**Gender** (F/M)	**Social Security Number**
Select one:				Select one	
Select one:				Select one	
Select one:				Select one	
Select one:				Select one	
Select one:				Select one	

EMPLOYEE CERTIFICATION AND SIGNATURE:

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a "change in status" or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

EMPLOYEE SIGNATURE: DATE: