



Superior Vision
Our Members. Our Mission.

VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by:

Superior Vision Services

11101 White Rock Road, Suite 150

Rancho Cordova, CA 95670



Enrollment Form

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION						
Employer Name County of Hertford		Group Number 28252	Location	Effective Date	Date of Hire	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name	First Name	M.I.	Date of Birth	Social Security Number	
Home Street Address		City/State/Zip		Home Phone ()		Work Phone ()
Email Address					Cell Phone ()	
ELECTION(S)						
Employee Only <input type="checkbox"/>		Employee + Family <input type="checkbox"/>				

FAMILY INFORMATION (Only those eligible may be enrolled.)						
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Signature: _____	Date: _____
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ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.