Enrollment/Change Form

VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by: Beam Insurance Administrators
PO Box 300
Burlington, KY 41005

Please print and complete all sections.

GROUP/EMPLOYEE/MEMBER INFORMATION	**A: Add (enroll) T: Terminate C: Change (change of name or coverage)**				
Group/Policyholder Name	**Group Number**	**Location**	**Effective Date**		**Date of Hire**

☐ A ☐ T ☐ C **Sex** ☐ M ☐ 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** ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)
Note: Children and Stepchildren of your Spouse or Domestic Partner are also eligible.

☐ A ☐ T ☐ C **Sex** ☐ M ☐ F	**Last Name (Spouse or Domestic Partner)**	**First Name**	**M.I.**	**Date of Birth**	
☐ A ☐ T ☐ C **Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Child unmarried and full-time student or handicapped?** ☐ **Yes** ☐ **No**
☐ A ☐ T ☐ C **Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	☐ **Yes** ☐ **No**
☐ A ☐ T ☐ C **Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	☐ **Yes** ☐ **No**
☐ A ☐ T ☐ C **Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	☐ **Yes** ☐ **No**

NOTE for VISION: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.

Employee Signature:_____ Date: _____

I elect the following coverage(s):

☐ Vision
- ☐ Employee Only $____
- ☐ Employee + Spouse $____
- ☐ Employee + Child(ren) $____
- ☐ Employee Family $____
- ☐ Waived due to other coverage
- ☐ Waive

Do you or any of your dependents have other vision insurance? ☐ Yes ☐ No

If yes, please give: Policyholder_____ and Insurance Company_____.

Declination of coverage must be accompanied by the Employee's signature above.

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