

AIG Vision Care

Enrollment Form for Group Vision Coverage

Print or Type

Employer (Group) Name _____

Group No./ Division/ Class _____

Applicant's Full Name _____ Social Security Number ____ - ____ - ____

Address _____

City _____ State _____ Zip Code _____

Date of Birth / / Scheduled hours per week _____
mm dd yr

Effective Date of Coverage / / Relationship to insured of dependents _____
mm dd yr

First day of full-time employment with current employer / /
mm dd yr

- Active Retiree
- Male Female

Vision Coverage Requested

(Select Coverage Option)

- Employees Only Employee and Family
- Employee and Spouse Employee and Child(ren)

Preferred Written Language (Optional): English Spanish Chinese Vietnamese Tagalog Other _____ Declined to State

Preferred Spoken Language (Optional): English Spanish Chinese Vietnamese Tagalog Other _____ Declined to State

Race (Optional): White/Caucasian American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander
 Other _____ Declined to State

Ethnicity (Optional): Of Hispanic or Latino Origin Not of Hispanic or Latino Origin Other _____ Declined to State

Complete the following for all family members for whom you are requesting coverage

Name	Student (Yes/No)	Gender (M/F)	Date of Birth (mm/dd/yr)

I want to be insured, I acknowledge that I have read, understand and agree to the terms and conditions of this coverage as detailed in the brochure and I authorize premium deductions from my pay for the insurance applied for. I understand that I can only make changes to the insurance applied for if I have a family or work status change.

I do not wish to enroll at this time.

Signature _____ / /
mm dd yr