

Underwritten by: National
Guardian Life Insurance
Company

Employee Benefits VISION INSURANCE



Administered by:
Advantica EyeCare
3290 Pine Orchard Lane, Suite D
Ellicott City, MD 21042

Enrollment / Change Form
Please print and complete all sections.
See instructions below.

EMPLOYER / EMPLOYEE INFORMATION

Employer Name Cultural Alliance of Greater Washington		Group Number CAGW	Location	Effective Date	Date of Hire
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Employee or Subscriber)	First Name	M.I.	Date of Birth*	Social Security Number**
Home Street Address		City / State / Zip		Home Phone ()	Work Phone ()

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*
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)	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*
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)	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*

* Required to associate Dependent(s) with Subscriber
** Required to process enrollment

Employee Signature: _____ Date: _____

I elect the following coverage: **SELECT PLUS 100 PLAN**
VOLUNTARY
Copays \$10/\$10; Frequency 12/12/12

MONTHLY PREMIUM

EE
 EE+1
 EF
 Waived

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

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.