SUPERIOR VISION

Superior Vision Insurance Plan of Wisconsin, Inc.

ENROLLMENT FORM

Employer: _____ Group Number: _____

Dept/Location: _____ Date of Hire: _____ Effective Date: _____

Employee Name: _____
First M.I. Last

Employee Soc. Sec. # _____-_____-_____ Sex: ☐ M ☐ F

Employee Birthdate: _____/_____/_____ Home Phone: (_____)_____

Home Address: _____

City: _____ State: _____ Zip: _____

COVERAGE: ☐ SINGLE ☐ LIMITED FAMILY (employee + spouse or employee + child or children) ☐ FAMILY

PLAN: ☐ FULL SERVICE (exam & materials) ☐ WAIVE

COVERED DEPENDENTS

NAME	BIRTHDATE	RELATIONSHIP	SOC. SEC. #
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -

EMPLOYEE SIGNATURE: _____ DATE: _____

IN ORDER FOR US TO PROPERLY PROCESS YOUR ENROLLMENT, WE WILL NEED ALL INFORMATION ON THIS FORM FILLED OUT AT TIME OF ENROLLMENT. THANK YOU.

Superior Vision Insurance Plan of Wisconsin, Inc.
11101 White Rock Road, Rancho Cordova, CA 95670
Phone: 1-800-507-3800 Fax: 1-916-852-2290 Email: commercialgroupadmin@superiorvision.com