

FIDELITY SECURITY LIFE INSURANCE COMPANY

Policy No. VC-4

VISION CARE PLAN - EMPLOYEE ENROLLMENT FORM

Employer Name: _____

Employee's Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Relationship:	Last Name	First	Middle Int.	Date of Birth			Sex	
				Mo	Day	Yr	M	F
Employee				/	/			
Spouse				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			

Employee Signature _____ Date: _____

Please complete enrollment form by typing or printing in ink.

A-00713

Policy Form #M-900 93-30668

FIDELITY SECURITY LIFE INSURANCE COMPANY

Policy No. VC-4

VISION CARE PLAN - EMPLOYEE ENROLLMENT FORM

Employer Name: _____

Employee's Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Relationship:	Last Name	First	Middle Int.	Date of Birth			Sex	
				Mo	Day	Yr	M	F
Employee				/	/			
Spouse				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			
Child				/	/			

Employee Signature _____ Date: _____

Please complete enrollment form by typing or printing in ink.

A-00713

Policy Form #M-900 93-30668