

## EyeMed Vision Plan University of Illinois Vision Care Enrollment Form

1. Are you a Graduate Assistant or Fellow with a waiver generating assistantship or fellowship between 25% and 67% that provides waivers of either full tuition or base-rate tuition? <i>(If "Yes," please complete in order to enroll your dependents.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you a Graduate Student that does not have an Assistantship or Fellowship but you still want to enroll yourself and/or your dependents for coverage? <i>(If "Yes," please complete in order to enroll.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*NOTE: Either one or the other apply – please do NOT check "Yes" to both 1 and 2.*

Policy No. VC-19

Student's Name: \_\_\_\_\_ University ID No. (UIN): \_\_\_\_\_

Social Security No.:\* \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Dependent Information (Complete ONLY if coverage is desired.)

Name	Gender	Relationship	Social Security No.*	Date of Birth
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*\*Must provide Social Security Number in order to enroll.*

Student Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

A-00713

M-9059

**Premium Payment Authorization (Please select one):** *Note: All premiums will be billed on an annual basis.*

Electronic Funds Transfer from checking account number: \_\_\_\_\_

Name as it appears on account: \_\_\_\_\_

*(You must include a voided check with this authorization.)*

Credit Card – Charge to account indicated below:

I authorize you to charge my insurance premiums, as provided to me by the Insurer, on an annual basis to the following credit card. I understand that if I wish to discontinue this authorization or if my credit card number changes, I will notify Fidelity Security Life Insurance Company in writing.

MasterCard  VISA Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Billing Address (if different than above): \_\_\_\_\_  

Street
City
State
Zip Code

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

**Return Completed Form To:**

Fidelity Security Life Insurance Company® • 3130 Broadway • Kansas City, MO 64111  
 Underwritten by FIDELITY SECURITY LIFE INSURANCE COMPANY®

**Questions? Call 1-800-648-8624**