

*Superior Vision Plan is an insurance policy issued by ReliaStar Life Insurance Company*



**Employer Information**

Policy Number **27422** Effective Date \_\_\_\_\_

Authorize Signature \_\_\_\_\_ Date \_\_\_\_\_

**Type of Coverage - to be completed by employee**

Employee Only	<input type="checkbox"/>
Employee + One Dependent	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>

**Employee Information - to be completed by employee**

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Male  Female

**Dependent Information - to be completed by employee**

First Name	MI	Last Name	Sex M/F	Date of Birth	Relationship	Social Security

**Employee please sign below**

\_\_\_\_\_  
Signature Date

- 1) Please type or print all information when completing this form.
- 2) Please complete all the information under the "Employee Information" and "Dependent Information" headings.
- 3) Please review the enrollment form to ensure all information is accurate and readable. Sign and date form.
- 4) Upon completion of this form, return it to your Benefits Office or other designated employer location.