

## Vision Insurance Enrollment/Change Form

**INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. Complete form legibly in Blue or Black Ink**

|  |                              |                                |                                  |
|--|------------------------------|--------------------------------|----------------------------------|
| <b>Name of Employer/Plan Sponsor:</b><br>North Dakota Public Employees Retirement System | <b>Group/Plan:</b><br>350308 | <b>Agency/Department Name:</b> | <b>Agency/Department Number:</b> |
|--|------------------------------|--------------------------------|----------------------------------|

|   |  |
|---|--|
| <b>This change is due to:</b><br><input type="checkbox"/> Initial Eligibility Following Hire<br><input type="checkbox"/> Annual Enrollment<br><input type="checkbox"/> Late Entrant due to Change in Family Status*<br><input type="checkbox"/> Change Agency from _____ to _____<br><input type="checkbox"/> Address Change<br><input type="checkbox"/> Add Dependent<br><input type="checkbox"/> Remove Dependent<br><input type="checkbox"/> Cancel Coverage<br><input type="checkbox"/> Loss of Other Coverage<br><input type="checkbox"/> Termination<br><input type="checkbox"/> Retirement | <b>Effective Date of Coverage or Change:</b> |
|---|--|

\* A late entrant is an individual who is first enrolling for vision coverage after the first available opportunity.

|   |  |  |  |
|---|--|--|--|
| <b>Employee Name (last, first, middle initial)</b>              | <input type="checkbox"/> Female<br><input type="checkbox"/> Male   | <b>Date of Birth</b><br>/ /  | <b>Social Security #</b>                 |
| <b>Employee Address (street address, city, state, zip code)</b> | <input type="checkbox"/> Single<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Legally Separated | <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed | <b>Telephone</b><br>Work ( )<br>Home ( ) |

### Elect Coverage

|  |  |
|--|--|
| <input type="checkbox"/> Employee Only     | <input type="checkbox"/> Employee + Child(ren) |
| <input type="checkbox"/> Employee + Spouse | <input type="checkbox"/> Employee + Family     |

### Waive Coverage

IF YOU DO NOT WANT COVERAGE< COMPLETE THIS WAIVER SECTION.

I have been given the opportunity to apply for Group Vision Insurance offered by the employer, and have decided not to accept the offer for (check all that apply):  myself  spouse only  child(ren) only  myself and entire family  
 because:  I have other coverage through my spouse's employer  I have other individual coverage  Other \_\_\_\_\_  
 Should I desire to apply for vision insurance in the future, I realize that a "late entrant" penalty may be applied.

### Dependent Information Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.

| Dependent Name<br>(last, first, middle initial) | Relationship to Employee | Gender<br>(F or M) | Date of Birth | Marital Status* | Child Status** | Add or Delete |
|---|--------------------------|--------------------|---------------|-----------------|----------------|---------------|
|   |                          |                    |               |                 |                |               |
|   |                          |                    |               |                 |                |               |
|   |                          |                    |               |                 |                |               |
|   |                          |                    |               |                 |                |               |

\* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.

\*\* For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

### Other Vision Coverage Information Complete if you and/or any dependent have vision coverage with another insurer or carrier.

| Employee/Dependent Name<br>(last, first, middle initial) | Name and Address of Other Vision Insurer/Carrier | Policy/Plan Number | Effective Date | Other Vision Coverage Type   |
|--|--|--------------------|----------------|--|
|  |  |                    |                | <input type="checkbox"/> Single<br><input type="checkbox"/> Family |
|  |  |                    |                | <input type="checkbox"/> Single<br><input type="checkbox"/> Family |

### READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium for the elected coverage
- To the best of my knowledge and belief, the information I have provided on this form is correct
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime
- I understand my coverage begins on the effective date assigned by the vision carrier, provided I am actively at work

|                      |             |
|----------------------|-------------|
| Employee's Signature | Date Signed |
|----------------------|-------------|

Ameritas Life Insurance Corp.  
Vision Enrollment Change Form

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

**Elect Coverage**

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

**Waive Coverage**

Select who is waiving coverage.

**Other Vision Coverage**

Indicate if you and/or any dependent have other vision coverage.

**You must sign and date this form for it to be valid.**