



SUPERIOR VISION

*Superior Vision Insurance Plan of Wisconsin, Inc.*

**ENROLLMENT FORM**

Employer: <u>Fond Du Lac County</u>	Group Number: <u>212601</u>
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)  MATERIALS ONLY  EXAM ONLY  WAIVE

**COVERED DEPENDENTS**

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

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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