

## University of Illinois EyeMed Vision Plan Voluntary Enrollment Form

1. Are you a Graduate Student with a waiver-generating assistantship or fellowship? <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 a waiver-generating Assistantship or Fellowship but you want to enroll yourself and/or your dependents/domestic partner 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 applies – do NOT check "Yes" to both 1 and 2.

Policy No. VC-19

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

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

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

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

Dependent/Domestic Partner Information (Complete ONLY if coverage is desired.)

Name	Gender	Relationship	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

A-00713

M-9059

**Premium Payment:** \$23.52 per person voluntarily enrolled.

Once a member enrolls they will receive detailed information in the mail along with a subscriber identification card.

**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, 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

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

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**