HM LIFE INSURANCE COMPANY OF NEW YORK

Vision Benefits
Employee Enrollment Form

☐ New Enrollee ☐ Termination ☐ Change of Status ☐ Change of Address

SECTION I: GROUP INFORMATION

Group Name			Group Number
Utica College			X06-540325
Division	**Class**	**Department**	**Effective Date**

SECTION II: EMPLOYEE INFORMATION

Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female

Address	City	State	Zip Code

Do you have eligible dependent children? ❒ Yes ❒ No

SECTION III: DEPENDENT INFORMATION

Spouse Name (Last, First, M.I.) *(if applying for spousal coverage)*	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female

Other Eligible Dependent Information *(if additional space is needed, please attached a separate sheet of paper)*

Name	Date of Birth	Gender	Relationship
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

SECTION IV: VISION COVERAGE SELECTIONS

Coverage Choice *(check one coverage only)*:

☐ Employee Only ($5.91) ☐ Employee+1 ($10.63) ☐ Employee+Family ($16.54)

I represent that the information provided above is true and correct to the best of my knowledge and belief. For those coverages I have declined, I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event. If the plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Employee Signature _____ Date _____

REFUSAL OF GROUP COVERAGE:
I have been offered and decline to purchase the Vision coverage(s) at this time. I understand that in the event I desire such insurance at a later date, I may be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Employee Signature _____ Date _____

TERMINATION OF COVERAGE:
I wish to terminate my Vision coverage. I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event.

Employee Signature _____ Date _____

Return this form to the Office of Human Resources

Administered by:
DAVISVISION℠
SEE LIFE

Applicants applying for accident and health insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Underwritten by HM Life Insurance Company of New York

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