ADVANTICA INSURANCE COMPANY
Vision Enrollment/Change Form

PLEASE PRINT AND COMPLETE ALL SECTIONS.

Please send completed, signed application to:

E-mail – eligibility@advanticabenefits.com

Mail -
9735 Landmark Parkway Drive, Suite 101
St Louis, MO 63127

Or call toll-free - ***866-425-2323***

www.advanticabenefits.com

- ☐ New applicant for coverage – complete sections 1, 2, 3 and 4.
- ☐ Change/Subscriber Authorization Form – Section 1, 3 and 4 must be completed. Complete sections 2 and 3 as applicable for change requested.
- ☐ I do not wish to enroll. (Declination of coverage must be accompanied by the employee's signature on the other side of this page)

SECTION 1 – EMPLOYEE INFORMATION

Group Name CAPITAL AREA COMMUNITY ACTION AGENCY	**Group # / Sublocation #** 11039001	**Division/Store Location**	
Employee Last Name	**First Name**		**Gender** ☐ M ☐ F
Social Security Number *	**Date of Birth** (mm/dd/yyyy) ** ___ / ___ / _______	**Coverage Effective Date** (mm/dd/yyyy) ___ / ___ / _______	
Street Address			
City	**State**	**Zip Code**	☐ Check here if new address
Employee Hire Date (mm/dd/yyyy) ___ / ___ / _______	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		

SECTION 2 – SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a second form for additional dependents if needed.
IMPORTANT: For court-ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

Level of Coverage:

☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

Gender	Last Name	First Name	M.I.	Date of Birth ** (mm/dd/yyyy)
Gender ☐ M ☐ F	**Last Name (Spouse)**	**First Name**	**M.I.**	
Gender ☐ M ☐ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/______
Gender ☐ M ☐ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/______
Gender ☐ M ☐ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/______
Gender ☐ M ☐ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/______
Gender ☐ M ☐ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/______

****Required to process enrollment***
***** Required to associate dependent(s) with subscriber***

Continued on next page. **No action requested can be taken without your signature.**

ADVANTICA INSURANCE COMPANY - VISION ENROLLMENT FORM

SECTION 3 - CHANGE OF COVERAGE

Coverage change:

❑ Employee Only ❑ Employee and Spouse ❑ Employee and Child(ren) ❑ Family

Name change:

From: Last Name: ________________________________ First Name: _________________________________

To: Last Name: ________________________________ First Name: _________________________________

Reason for change *(All changes must be made within 31 days of the qualifying event)*

Additions:

Effective date of addition: ___ / ___ / ______

- ❑ Birth
- ❑ Marriage
- ❑ Adoption (attach legal documentation)
- ❑ Court-ordered dependent (attach legal documentation)
- ❑ Open enrollment
- ❑ Other (describe) _______________________________

Cancellations:

Effective date of cancellation: ___ / ___ / ______

- ❑ Death
- ❑ Employee terminated on ___ / ___ / ______
- ❑ Divorce
- ❑ Dependent reached student/dependent maximum age
- ❑ Retired
- ❑ Other (describe) ______________________________

Transfer membership:

Transfer effective date: ___ / ___ / ______

From:

Group # / Sublocation #: __________________________

Division / Store Location: ___________________________

To:

Group # / Sublocation #: __________________________

Division / Store Location: ___________________________

SECTION 4 - EMPLOYEE AUTHORIZATION

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under my group's contract or the Member Certificate/Master Policy issued to me or with respect to my coverage. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my group may act as my agent for this coverage. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any provider of care to furnish Advantica Insurance Company, Advantica Administrative Services, Inc. and any of their contractors, with any necessary or requested information regarding care or treatment of myself or any covered dependents. I understand that courses of vision treatment which began before my effective date may not be covered. I understand that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract and/or Member Certificate/Master Policy. I understand that if my group has purchased an insured vision product, the insured vision product is underwritten by Advantica Insurance Company and administered by Advantica Administrative Services, Inc. I understand that if my group has purchased vision administrative services only, the vision product is not insured or underwritten by Advantica Insurance Company, and the vision administrative services are provided by Advantica Administrative Services, Inc.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

____ ____ / ____ / ________

Employee Signature Date

No action requested can be taken without your signature above.