The Business Council INSURANCE FUND

Vision Perfect Enrollment Form
(or waiver)

Group No.	Employer:	Date Hired		
		Month	Day	Year

Employee Name (Last, First, Middle)	Gender		Date of Birth			Social Security #		
	M	F	Month	Day	Year			
	☐	☐						

If enrolling for coverage, please complete this section

I am enrolling for Vision Perfect coverage as indicated:

☐ Employee only ☐ Employee/Child ☐ Employee/Spouse ☐ Family

Employee Statement - Enrolling for Coverage

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation;(b) I must be regularly working at my employer's business establishment or at some other location to which my employer's business requires me to travel, and (c) I have completed any applicable waiting period.

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required. I further understand that if I do not make the required written application within thirty one (31) days of my eligibility date, the Vision Perfect benefits will be subject to a one-year waiting period which begins on the date I make written application.

Employee Signature **Date** **Certified** **Employer Representative** **Date**

Dependent Insurance

Effective	Name of Eligible Dependents to be Covered*	Date of Birth	Relationship

*The term "dependent" is limited to the employee's spouse, unmarried child to age 19, and unmarried children from 19 to 25 who are registered full-time students, principally dependent on the employee for maintenance and support, residing in the United States or Canada.

If waiving coverage, please complete this section

I decline to enroll for Vision Perfect insurance for the reason(s) indicated. Please check appropriate box(es)

	Covered under spouse	Other
☐ Myself	☐	☐
☐ My spouse	☐	☐
☐ My dependent child(ren)	☐	☐

EMPLOYEE STATEMENT - Waiving Coverage

I hereby certify that I have been given an opportunity to request Vision Perfect coverage available to me and my dependents through my employer. I further understand that if I desire to participate in the Plan and do not make the required written application within thirty-one days of my eligibility date, the Vision Perfect benefits will be subject to a one-year waiting period which begins on the date I make written application.

Employee Signature **Date** **Certified** **Employer Representative** **Date**