CLEAR

SAVE

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Gerber Life Insurance Company
1311 Mamaroneck Avenue
White Plains, New York 10605

Mail to: **Medical Eye Services, Inc.**
P.O. Box 25209
Santa Ana, CA 92799

Enrollment Form for Large Group Coverage
For New Enrollment/Change Request – Please Submit This Form to Your Employer

Employee Effective Date:	
Group Number:	34180
Sub-Group Number:	N/A

Employee Information

Last Name:	First Name:		MI:
Address:	Employee ID No./Social Security No.:		Date of Birth: (mm/dd/yyyy)
City:	State:	Zip Code:	Date of Hire: (mm/dd/yyyy)
Gender: ☐ Male ☐ Female ☐ Nonbinary	Employee Email Address:		Employer Name:

Please Enroll/Change My Plan as Indicated

☐ New Enrollee ☐ Add Dependent(s) ☐ Delete Dependent(s) | Qualifying Event Date:

Eligible dependents may be your spouse, domestic partner and unmarried children as stated in your policy. Coverage granted to individuals listed herein shall be subject to all provisions and limitations of the Vision Plan Certificate and any applicable Rider.

☐ Change my name as shown. My former name is:

List Below All Eligible Dependents to be Covered

Last Name	First Name	MI	Relationship	Gender	Address, if different from Employee	Date of Birth (mm/dd/yyyy)	Change
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete
				☐ Male ☐ Female ☐ Nonbinary			Effective Date ________ ☐ Add ☐ Delete

Note: Nonbinary is defined by the state of CA as people with gender identities that fall outside of the traditional conceptions of strictly either female or male.

Disclosure

THIS IS VISION-ONLY INSURANCE, UNLESS A HEARING BENEFIT RIDER TO THE VISION POLICY IS SELECTED. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Attestation

I attest that I have Minimum Essential Coverage ☐ Yes ☐ No

Every eligible employee must sign this enrollment form. If you are declining coverage for yourself or dependents, please complete the section below:

Waiver of Coverage

I have been given the opportunity to apply for my company's group vision insurance and have decided to proceed as follows:

- ☐ I am applying for myself only and declining dependent coverage.
- ☐ I decline coverage on dependents and myself.
- ☐ Other:

Signature: _____ Date: _____

Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Note to Group Administrators

All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.

Medical Eye Services, Inc. (MESVision) is the administrator for the Vision Care Preferred Provider Insurance Policy.

FRAUD WARNING

NOTICE TO CALIFORNIA APPLICANTS: THE FALSITY OF ANY STATEMENT IN THE APPLICATION FOR THIS POLICY SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THIS POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY US.