

**FIDELITY SECURITY LIFE INSURANCE COMPANY**

**ELECTION OF CONTINUED EMPLOYEE VISION INSURANCE**

**NOTE:** Vision Insurance may be continued subject to COBRA guidelines and state continuance laws.

**TO BE COMPLETED BY EMPLOYER:**

Employer's Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Account #:

Name(s) of Employee and Dependent(s) eligible for contribution:

Employee's Social Security #: \_\_\_\_\_ Date eligible for continuation:

Date and reason insurance is terminating:

Cost of insurance per month on date eligible for continuation: Employee \$ \_\_\_\_\_ Dependent(s) \$

**NOTE:** Premiums are subject to change for continuing insureds for the same reasons as premiums may change for active employee insureds.

Authorized Employer's Signature \_\_\_\_\_ Date

**TO BE COMPLETED BY THE APPLICANT FOR CONTINUED INSURANCE:**

- Please check one:
- I do not wish to continue my vision coverage. I understand that my insurance under this policy will cease as of the date eligible for continuation listed above.
  - I do wish to continue my vision insurance coverage. I understand that timely payment of the premium to the employer is required to keep the insurance in force. I am enclosing with this form my first premium payment, made payable to the employer.

Applicant's Signature \_\_\_\_\_ Date