FIDELITY SECURITY LIFE INSURANCE COMPANY

Policy No. VC-4

VISION CARE PLAN - EMPLOYEE ENROLLMENT FORM

Employer Name: ____

Employee's Name: _________________________________ Social Security #: ___________________________

Address: ____

City: ______________________ State: ______ Zip: ______________ Phone #: ________________________

Relationship:	Last Name	First	Middle Int.	Date of Birth Mo Day Yr	Sex M	F
Employee				/ /		
Spouse				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		

Employee Signature ____ Date: __________________

Please complete enrollment form by typing or printing in ink.

A-00713 Policy Form #M-900 93-30668

FIDELITY SECURITY LIFE INSURANCE COMPANY

Policy No. VC-4

VISION CARE PLAN - EMPLOYEE ENROLLMENT FORM

Employer Name: ____

Employee's Name: _________________________________ Social Security #: ___________________________

Address: ____

City: ______________________ State: ______ Zip: ______________ Phone #: ________________________

Relationship:	Last Name	First	Middle Int.	Date of Birth Mo Day Yr	Sex M	F
Employee				/ /		
Spouse				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		
Child				/ /		

Employee Signature ____ Date: __________________

Please complete enrollment form by typing or printing in ink.

A-00713 Policy Form #M-900 93-30668