

STATE EMPLOYEES' INSURANCE BOARD

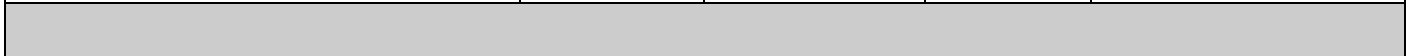
Southland National Supplemental Vision Insurance Enrollment/Cancellation Form

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex	Effective Date <small>(Must be on the 1st day of the month)</small> / /
Social Security Number		Date of Birth	<input type="checkbox"/> Vision (Monthly premium \$24) A minimum enrollment of 12 months required for employees/dependents <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage (List dependents below.) <input type="checkbox"/> Cancel Coverage
Mailing Address			
City	State	ZIP Code	
Home Telephone Number ()	Work Telephone Number () Ext:		

E-mail Address:

First Name	Initial	Last Name	(Documentation is Required) Relationship to Employee	Date of Birth	Social Security Number
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		



AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the SEIB's behalf.

 Employee Signature _____
Date

GENERAL INFORMATION

ELIGIBLE DEPENDENTS

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) **(Appropriate documentation must be attached.)**

1. Your spouse (excludes divorced or common law spouse)
2. An unmarried child under age 19, only if the child is:
 - a. your son or daughter
 - b. a child legally adopted by you (including any probationary period during which the child is required to live with you)
 - c. your stepchild
 - d. your grandchild, niece or nephew for whom the court has granted you legal custody (provided the child is not eligible for any other group health insurance benefits).
3. Children ages 19 through 25 who are full-time unmarried students attending an accredited institution. An annual student verification letter from the institution must be filed with the SEIB.
4. An incapacitated dependent will be considered for coverage to any age provided the dependent:
 - a. is unmarried,
 - b. is permanently mentally or physically disabled or incapacitated,
 - c. is so incapacitated as to be incapable of self-sustaining employment,
 - d. is dependent upon the subscriber for 50% or more support,
 - e. is otherwise eligible for coverage as a dependent except for age, and
 - f. the condition must have occurred prior to the dependent's 19th birthday (unless already covered by the SEIB as a student, in which case the condition must have occurred prior to the dependent's 26th birthday).

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would otherwise cease to be covered because of age.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

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