

**Ameritas Group
Vision Enrollment Form**

Employer Name _____

Employee Name	
Date of Birth	
Social Security Number	
Home Address	
Date of Employment	
Occupation	
Hours worked per week	
Plan Selected (circle one)	High Plan Low Plan
List Dependents Below (Along with Relationship if applicable)	

Signature: _____ **Date:** _____

Waiver of Coverage: I waive coverage for myself and/or my dependents.

Signature: _____ Date: _____