

TO BE COMPLETED BY GROUP BENEFITS OFFICE:

Effective Date: _____/_____/_____

Group # _____

Plan Variation Vision _____

Reporting Code Vision _____

Vision Plan Enrollment Form

Organization Name: _____

1. Check the Appropriate Boxes

Coverage Desired <input type="checkbox"/> Employee Only \$ _____ <input type="checkbox"/> Employee + Family \$ _____		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Status/Address <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA EFFECTIVE DATE: _____	REASON FOR CHANGE IN STATUS <input type="checkbox"/> Termination <input type="checkbox"/> Newborn Child <input type="checkbox"/> Adoption/legal custody <input type="checkbox"/> Dependent child married/reached age limit				<input type="checkbox"/> Death <input type="checkbox"/> Last Name	<input type="checkbox"/> Marriage <input type="checkbox"/> Other Insurance <input type="checkbox"/> Legal custody of parent	<input type="checkbox"/> Divorce <input type="checkbox"/> Move to COBRA
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2. Employee Information (please print clearly):

Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

Your Name: _____
(First) (Middle Initial) (Last)

Address: _____
(City) (State) (Zip)

3. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full-Time Student?	Gender
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

Florida Residents Only: NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Your Signature _____ Date _____