Enrollment Application - Please print or type

Vision Care Plan

A ENROLLEE

Name First Middle initial Last _____

Social security number ____/____/____

Employee Status
( ) Full-time
( ) Part-time

Hire Date	Does your spouse have a vision plan?	If yes, who is covered?	Other insurance company name?
____/____/____ Month Day Year	( ) Yes ( ) No	( ) Yourself ( ) Spouse ( ) Dependent Children	_____

Birth Date	Sex	Marital Status	Are You Enrolling Your Dependents (Spouse/Children) in The Vision Care Plan?
____/____/____ Month Day Year	( ) Male ( ) Female	( ) Single ( ) Married	( ) Yes - Complete Section C ( ) No

Address _____ Telephone ( ) _____

City _____ State & Zip _____

B ACTION REQUESTED

( ) New enrollment

( ) Change to existing Enrollment

( ) Add New Dependent
( ) Delete Dependent
Effective date of change ____/____/____

Reason for change

_____

_____

_____

C DEPENDENTS

Spouse name First	Middle initial	Last (if different)	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Month Day Year
					/ /	/ /

Child name First	Middle initial	Last (if different)	Add/ Delete	Sex M F	Birthdate Month Day Year	If child is 21 or over (Check one) Full-time Student	Disabled
1.					/ /		
2.					/ /		
3.					/ /		
4.					/ /		

D SIGNATURE

_____ Employee Signature

_____ Date

FOR OFFICE USE ONLY

Group number _____

Effective Date _____

Period Ending _____