VISION BENEFITS OF AMERICA 874 SUBGROUP _______________
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE _________/___________/___________

INSTRUCTIONS FOR EMPLOYEE:

1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER ____

EMPLOYEE NAME __________________________________ BIRTHDATE ____|______|______

ADDRESS ____

CITY ________________________ STATE__________ZIP CODE ___________-___________

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

FIRST NAME MIDDLE INITIAL LAST NAME BIRTHDATE

SPOUSE ____|______|______

CHILD ____|______|______

CHILD ____|______|______

CHILD____|______|______

CHILD____|______|______

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME NAME OF SCHOOL OR UNIVERSITY

____|_______|_____

____|_______|_____

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME

____|_________|_____

EMPLOYEE SIGNATURE __________________________________ DATE ______/_____/_____