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 _____/_____/_____