

VISION SERVICE PLAN

ENROLLMENT / CHANGE / TERMINATION FORM

(PLEASE PRINT)

EMPLOYEE NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

Effective Date: _____

This is a(n):

- Enrollment (initial eligibility, qualifying event, or Open Enrollment)
- Change (addition or deletion of dependents)
- Termination (cancellation of coverage)

COVERAGE LEVEL (PLEASE CHECK ONE):

- EMPLOYEE ONLY \$ 14.28/ MONTH
- EMPLOYEE + SPOUSE \$ 23.68 / MONTH
- EMPLOYEE + CHILD (REN) \$ 22.58 / MONTH
- EMPLOYEE + FAMILY \$ 35.30 / MONTH

EMPLOYEE SIGNATURE: _____

DATE: _____

GROUP NUMBER: 12103137
DIVISION NUMBER: 0001