Vision - Enrollment Form

EMPLOYEE INFORMATION

Last Name______________________________ **First Name**______________________________ **Sex:** ☐ Male ☐ Female

Address ______________________________ **City** ______________________________ **State**________ **Zip Code** __________

Date of Hire____________________ **Benefits Eligibility Date** ____________________ **Date of Birth** ____________________

ENROLLMENT/CHANGES: ☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Life Event Change** **Effective Date:** ________/________/________

Basic Coverage - Check only one box:

Monthly Cost

Employee Only:	☐$ 0.00
Employee + Spouse:	☐ $ 0.00
Employee + Child(ren)	☐ $ 0.00
Family:	☐$ 0.00

OR

Enhanced Vision Coverage - Check only one box:

Monthly Cost

Employee Only:	☐$ 6.38
Employee + Spouse:	☐ $ 9.77
Employee + Child(ren)	☐ $ 10.01
Family:	☐$ 15.43

CANCELLATION OF COVERAGE: ☐ **Open Enrollment** ☐ **Life Event Change** **Effective Date:** ________/________/________

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

DEPENDENT INFORMATION - List all eligible dependents to be covered / cancelled from coverage. ***All fields must be completed when covering dependents.***

Enroll in Coverage	Cancel Coverage	Name (Last, First)	Social Security Number	Date of Birth	Relationship
☐	☐				
☐	☐				
☐	☐				
☐	☐				

I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize the company to deduct from my pay on a pre-tax basis and remit any required contribution for the cost of coverage. This authorization is to remain in effect until I notify the company in writing of any changes. I also understand that I cannot change my benefit elections or cancel my coverage until the next Open Enrollment period unless I have experienced a Life Event as defined by the Plan.

____ ____

Employee Signature **Date** **Human Resources Approval** **Date**