



# Vision Enrollment/Change Application 2018

**To be completed by Human Resources:**  
 Effective date: \_\_\_\_\_  
 Coverage effective 1<sup>st</sup> of month  
 Banner: \_\_\_\_\_ Website: \_\_\_\_\_

### 1. Reason for Application:

- New Enrollment
- Cancel Coverage
- Change Coverage

### New Enrollment Reason:

- New Hire
- Open Enrollment
- Qualifying Event

### Reason for Change of Status:

- Termination of prior coverage
- Newborn child
- Dependent Status Change
- Marriage
- Divorce
- Death

### 2. Coverage Election (monthly premiums):

#### Standard Plan

- Employee Only \$ 7.97
- Employee + One \$13.44
- Employee + Family \$21.21

#### High Plan

- Employee Only \$13.31
- Employee + One \$25.82
- Employee + Family \$40.81

### 3. Employee Information (please print clearly)

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Your Name \_\_\_\_\_  
 (First) (Middle) (Last)

Address \_\_\_\_\_  
 (Street/Apt #) (City) (State) (Zip)

### 4. Dependent Information (if electing dependent coverage)

|                  | First Name | Last Name | Date of Birth | Social Security | Gender | Full-time student? |
|------------------|------------|-----------|---------------|-----------------|--------|--------------------|
| <b>Spouse</b>    |            |           |               |                 |        |                    |
| <b>Dependent</b> |            |           |               |                 |        |                    |
| <b>Dependent</b> |            |           |               |                 |        |                    |
| <b>Dependent</b> |            |           |               |                 |        |                    |
| <b>Dependent</b> |            |           |               |                 |        |                    |
| <b>Dependent</b> |            |           |               |                 |        |                    |

I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

Employee signature \_\_\_\_\_ Date \_\_\_\_\_