Vision Coverage

ENROLLMENT FORM

Employer Information – *for employer use only*

Company Name____ Branch/Division #_________________________________

Policy Number ____ Effective Date___________________________________

Authorization Signature__________________________________ Date____

Type of Coverage – *to be completed by employee*

	High Plan	Low Plan (Materials Only)
Employee Only	☐	☐
Employee & One Dependent	☐	☐
Employee & Family	☐	☐

Employee Information – *to be completed by employee*

Social Security #_________/________/__________ Date of Birth______/______/______ Date of Hire______/_____/______

First Name___________________________________ MI_______ Last Name______________________________________

Street Address____

City____ State_______ Zip Code________________ Sex M ☐ F ☐

Home Phone # (____)__________________ Work Phone # (____)_________________ Job Title____________________

Dependent Information – *to be completed by employee*

First Name	MI	Last Name	Sex	Date of Birth	Relationship	Social Security #
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -
			M F	/ /		- -

____/______/_____________

Signature Date

Employee instructions for completing Vision Plan enrollment form

1. Please type or print all information when completing this form.
2. Please complete all the information under the "Employee Information" and "Dependent Information" headings.
3. Please review the enrollment form to ensure all information is accurate and readable. Sign and date form.
4. Upon completion of this form, return it to your Human Resources Office or other designated employer location.