

### EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex  Male  Female

Employer Group Name \_\_\_\_\_

Do you wish to cover your eligible Dependents?  Yes  No

Choose your Plan Option:  Option 1- Vision Exam & Materials (60790-1339)

Option 2- Materials Only (60790-1338)

**If yes, complete the following:**

Name	Date of Birth	Name	Date of Birth
Spouse _____	_____	Child _____	_____
Child _____	_____	Child _____	_____
Child _____	_____	Child _____	_____
Child _____	_____	Child _____	_____

Date \_\_\_\_\_ Signature \_\_\_\_\_

I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Group Number \_\_\_\_\_ Sub-Group (if applicable) \_\_\_\_\_ Plan Number \_\_\_\_\_

<input type="checkbox"/> <b>New Enrollment</b>	<input type="checkbox"/> <b>Add/Change</b>	<input type="checkbox"/> <b>Cancel Coverage</b>
___ Dependent	___ Name	___ Policy Holder
___ Address/Phone	___ Cobra	___ Dependent(s)

**Reason for Change:**  Employment Status  Qualifying Event

Please State Qualifying Event: \_\_\_\_\_

Member Effective Date: \_\_\_\_\_ Date of Employment: \_\_\_\_\_