

VISION

MEDICAL EYE SERVICES **GROUP ENROLLMENT APPLICATION & CHANGE FORM**

EYE CARE & EYE WEAR PLAN

EYE WEAR ONLY PLAN

EMPLOYER: _____ **EFFECTIVE DATE:** _____

ADDRESS: _____

COVERAGE TYPE:

1= Employee Only

2= Employee Plus 1 Dependent

3= Employee Plus 2 or More Dependents

BUSINESS PHONE: _____ **Employee's HOME PHONE:** _____

NEW ENROLLMENT

Social Security Number	Last Name	First Name	M.I.	Sex M/F	Date of Birth
- -	Employee				
XXXX	Spouse				
XXXX	Dependent				
XXXX	Dependent				
XXXX	Dependent				

CHANGES (CURRENTLY ENROLLED MEMBERS)

Employee Name: _____

Last

First

M.I.

Add Spouse/Date of Marriage Name: _____ Date of Birth: _____

Add Family Member(s) Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Delete Family Member(s) Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name Change/New Name: _____

Change of Address only/New Address: _____

EMPLOYEE'S SIGNATURE: *X* _____ **DATE:** _____