



# Vision Service Plan

**Effective Date:**

<input type="checkbox"/> Active (001) <input type="checkbox"/> Federal COBRA (002) Acct #: 12 178895	<input type="checkbox"/> Enroll <input type="checkbox"/> Change Dependent Status: <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Cancel Coverage
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**A Subscriber Information** (complete this section for new enrollment or change of status to its entirety)

Name			Social Security Number	Date Employed
_____			____ - ____ - _____	____ / ____ / ____
Last	First	M.I.	(Member I.D. Number)	
Birthdate		Gender	Marital Status	
____ / ____ / ____		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated	
Address		Apt. Number	Telephone Number	
_____		_____	( ) _____ - _____	
City		State	ZIP Code	
_____		_____	_____	

**B Change Existing Enrollment Forms** (Please select all that apply)

Name Change      Former Name: \_\_\_\_\_ New Name: \_\_\_\_\_  
 Add New Dependent  
 Delete Dependent  
 Address change (listed in Section A)

**C Dependents** (Complete this section to add, delete, or update dependent's information)

Spouse/LDA Name	Add/Delete	Sex	Birthdate	Social Security Number
_____	_____	_____	____ / ____ / ____	____ - ____ - _____
Dependent 1	Add/Delete		____ / ____ / ____	____ - ____ - _____
Dependent 2	Add/Delete		____ / ____ / ____	____ - ____ - _____
Dependent 3	Add/Delete		____ / ____ / ____	____ - ____ - _____

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

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