VISION BENEFITS OF AMERICA **VBA #580** SUBGROUP # _____________

ENROLLMENT FORM

COVERAGE EFFECTIVE DATE ______________________________

INSTRUCTIONS FOR EMPLOYEE:

COMPLETE SECTION BELOW AND SIGN.

RETURN COMPLETED FORM TO CINDI BAKER IN THE BUSINESS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER ____

EMPLOYEE NAME ____ BIRTHDATE ____________________

ADDRESS ____

CITY ____ STATE ___________ ZIP CODE _____________________

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED

	FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				

STUDENT INFORMATION (<u>Complete for dependents age 19-23 who are enrolled as Fulltime college students</u>)

STUDENT NAME	NAME OF SCHOOL OR UNIVERSITY	Expected Grad Date

ANY HANDICAPPED CHILD COVERED ON MEDICAL

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EMPLOYEE SIGNATURE ____ DATE _____________