VISION BENEFITS OF AMERICA **VBS # 580** **SUBGROUP# ___Active______**
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE ___________/___________/_____________

INSTRUCTIONS FOR EMPLOYEE:

COMPLETE SECTION BELOW AND SIGN.
RETURN COMPLETED FORM TO THE BENEFITS DEPARTMENT.

EMPLOYEE SOCIAL SECURITY NUMBER ____

EMPLOYEE NAME ____ BIRTHDATE _____/___/_____

ADDRESS ____

CITY ____ STATE __________ ZIP CODE _________________

PLEASE LIST ALL FAMILY MEMEBRS TO BE COVERED:

	FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE
SPOUSE				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____
CHILD				______/____/_____

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED AS FULL-TIME COLLGE STUDENTS)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	Expected Grad Date
		/ /
		/ /

ANY HANDICAPPED CHILD COVERED ON MEDICAL

CHILDS NAME	
	/ /
	/ /

EMPLOYEE SIGNATURE ____DATE __________________