



**PLEASE BE SURE TO FILL OUT AND SIGN THIS FORM,
And Return To Your Human Resources Department.
Group Vision Plan Enrollment Form**

Section A: EMPLOYEE INFORMATION				
EMPLOYEE NAME (LAST, FIRST, M.I.)			SOCIAL SECURITY NUMBER	
EFFECTIVE DATE:				
Address (number)		(street)	(city)	(state) (zip)
County		Home Phone		Work Phone
Company Name and Address				Date of Hire
Marital Status				Spouse's Name
<input type="checkbox"/> Single	<input type="checkbox"/> Family			
Section B: VISION COVERAGE:				
Do you or your dependants have vision coverage? YES _____ NO _____				
What is the name of your vision coverage insurer? _____				
Section C: VISION PLAN ENROLLMENT INFORMATION				
NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY NUMBER		EFFECTIVE DATE:
SPOUSE				
DEPENDANT				
DEPENDANT				
DEPENDANT				

I declare that all statements and information made are complete and true to the best of my knowledge. I understand that any fraudulent or intentional misstatements of material facts may void all coverage applied for on any member included on this enrollment application

DATE

SIGNATURE OF PROPOSED INSURED

DATE

SIGNATURE OF SPOUSE OR DEPENDENT

DATE

SIGNATURE OF DEPENDENT (age 18 or older)