VISION BENEFITS OF AMERICA **VBA#** **SUBGROUP#______**
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE __________/____________/____________

INSTRUCTIONS FOR EMPLOYEE:

1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS 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/PARTNER				___|______|______
CHILD				___|______|______
CHILD				___|______|______
CHILD				___|______|______
CHILD				___|______|______

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	
		___|_______|_____
		___|_______|_____

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME

____|_________|_____

EMPLOYEE SIGNATURE _______________________________________ DATE ______/_____/_____