Vision Plan

ENROLLMENT/CHANGE FORM

NAPEBT – 12239817

☐ Add
☐ Change
☐ Cancel

EFFECTIVE DATE: ______________ **EMPLOYEE'S SSN:**______________________

EMPLOYEE'S NAME: ____

EMPLOYEE'S DATE OF BIRTH: ____

☐ I WOULD LIKE TO ENROLL IN THE VSP EXAM PLUS PROGRAM.

☐ I WOULD LIKE TO ENROLL IN THE BUY UP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:

C ☐ EE Only
A ☐ EE+Family

PLEASE LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER:

SPOUSE: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________
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CHILD: __________________________ ☐Male ☐Female DOB__________
CHILD: __________________________ ☐Male ☐Female DOB__________

______________________________________ ________________
Signature Date

Please return to your Benefits Department
Do Not Return to Vision Service Plan