

**VISION BENEFITS OF AMERICA
ENROLLMENT FORM**

VBA# 1035

SUBGROUP# _____

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	BIRTHDATE
_____	_____	____ ____ ____
_____	_____	____ ____ ____

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME _____

EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____