

## Vision Plan Enrollment Form

TO BE COMPLETED BY BENEFITS OFFICE:	
Effective Date:	_____
Group#: GRTS - GRT	- 1000 _____
Plan Variation Vision:	_____
Reporting Code Vision:	_____

Organization Name: \_\_\_\_\_ City of Worcester \_\_\_\_\_

### I. Check the Appropriate Boxes

<b>Coverage Desired</b> <input type="checkbox"/> Employee Only      \$4.25 <input type="checkbox"/> Employee + One      \$8.50 <input type="checkbox"/> Employee + Family      \$12.75		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Status/Address <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Cancel Coverage	<b>REASON FOR CHANGE IN STATUS</b> <input type="checkbox"/> Termination <input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Newborn Child <input type="checkbox"/> Last Name/Address Change <input type="checkbox"/> Other Insurance <input type="checkbox"/> Move to COBRA <input type="checkbox"/> Adoption/legal custody of child <input type="checkbox"/> Legal custody of parent <input type="checkbox"/> Dependent child married/reached age limit
HIRE DATE: _____		EFFECTIVE DATE: _____	

### II. Employee Information (please print clearly):

Unique Member ID Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Gender  M /  F

Your Name \_\_\_\_\_  
 (First) (Middle Initial) (Last)

Address \_\_\_\_\_  
 \_\_\_\_\_  
 (City) (State) (Zip)

### III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Gender
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

**Florida Residents Only: NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_