National Vision Administrators
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				
CHILD				
CHILD				
CHILD				
CHILD				

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

STUDENT'S NAME	NAME OF SCHOOL OR UNIVERSITY

ANY HANDICAPPED CHILD COVERED ON MEDICAL?
CHILD NAME

EMPLOYEE SIGNATURE _____ DATE _____