VISION BENEFITS OF AMERICA **VBA# 1250**
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 _____