**VISION BENEFITS OF AMERICA** **VBA# 2433 SUBGROUP#_____**
**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**.)

| STUDENTS NAME | NAME OF SCHOOL OR UNIVERSITY | |
|---|---|---|
| | | |
| | | |

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

| CHILD NAME | | |
|---|---|---|
| | | |

EMPLOYEE SIGNATURE _____ DATE _____/_____/_____