

enrollment/change/waiver

group insurance form

COBRA: If individual is a continuee

Qualifying Event _____

Date of Event _____



Policy and Div. # 010- _____ Cert. # _____

Name and Address of Employer (Policyholder) _____

1 to enroll Eye Care To terminate all coverages

employee information Marital Status Single Married

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ Male Female

Full time date of hire _____ Rehire: Rehire date _____

Occupation _____

Hours worked each week _____ Are your earnings paid: Hourly or Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another eye care insurance plan? **Employee:** Yes No **Dependents:** Yes No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first, MI)	add	drop	date of birth	sex	date of birth	social security number
1 _____						
2 _____						
3 _____						
4 _____						
5 _____						
6 _____						

please sign (employee/policyholder) **The certificate provides eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____
Employee Signature (do not print) **Date**

X _____
Policyholder Signature (do not print) **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____

Effective Date	Class	Dep. Code

Dependent late entrant date _____

2 change

Name Change New Name _____ Old Name _____

- Add dependent coverage**
- If due to marriage, what is the date of marriage? _____
 - If due to birth/adoption, what is the date of event? _____
 - If due to loss of coverage, date and reason: _____
 - If other, the date of event and please explain: _____

Drop dependent coverage Number of dependents still covered: _____ Effective date of drop: _____

- Due to divorce Due to death Due to annual election period
- Other (please explain) _____