



# Member Application for Group Vision Coverage

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. All information provided should apply to this employer.

Date of Application \_\_\_\_\_  
 Date of Hire \_\_\_\_\_

Type of Enrollment:    \_\_\_ New Enrollment    \_\_\_ Change  
    \_\_\_ Addition            \_\_\_ Termination

### Employer Information

Employer Name: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Employee Information

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
 Home Address: City State & Zip \_\_\_\_\_  
 Home Phone (    ) \_\_\_\_\_ Business Phone (    ) \_\_\_\_\_ e-mail address \_\_\_\_\_  
 Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_            Active Employee \_\_\_\_\_ Retired Employee \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex  Male  Female            Social Security Number \_\_\_/\_\_\_/\_\_\_

### Dependent Information

First Name	Middle Initial	Last Name	DOB	Relationship
1.				
2.				
3.				
4.				
5.				
6.				

Check	Rate Structure	Premium
	Employee Only	
	Employee + Spouse	
	Employee + Child(ren)	
	Employee + Family	
	No Coverage (Waiver of Coverage should be provided)	

Signature required for payroll deduction:  
 \_\_\_\_\_  
 Employee Signature