VISION BENEFITS OF AMERICA **VBA# 2102** **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 _____/_____/_____