Vision Benefits of America
Clearly Managed. Clearly Focused.

VISION BENEFITS OF AMERICA ENROLLMENT FORM **VBA#** **SUBGROUP#**

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 _____/____/____