SFTLA VISION INSURANCE ENROLLMENT/CHANGE FORM

Please Print Or Type – Incomplete Information Will Delay Processing

For Company Use Only - Effective Date:

Check One
- **New Enrollment** ❐
- **Add Dependents** ❐
- **Delete Dependents** ❐
- **Address Change** ❐
- **Name Change** ❐

Employee Last Name	**First Name**	**M.I.**	
Home Address	**City**	**State**	**Zip Code**

Date of Birth	**Social Security #**	**Male** ❑ **Female** ❑	**Single** ❑ **Married** ❑	**If name change, give former name:**

Employer/Group Name		**Area Code/Phone #**	**Group Vision Policy #**
Your Occupation	**Full-Time Employment Date:**	**Rehire Date:**	**Average Hours Worked Per Week:**

PLEASE COMPLETE FOR DEPENDENT MEMBERS TO BE COVERED or REMOVED EFFECTIVE: __________________

Dependent/First Names (Last name if different)	**Sex (Circle)**	**Date of Birth**	**Dependent/First Names (Last name if different)**	**Sex (Circle)**	**Date of Birth**
Spouse*	**M F**		**Child-2**	**M F**	
Domestic Partner	**M F**		**Child-3**	**M F**	
Child-1	**M F**		**Child-4**	**M F**	

***Date of Marriage: _______________________ * If added to the employee's coverage after the employee's original effective date in the group plan.**

I hereby apply for Vision insurance for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time with written notice.

Please indicate coverage selection below

Employee Only ❑	**Employee & Spouse/ Domestic Partner** ❑	**Employee, Spouse & Children** ❑	**Employee & Children (No Spouse)** ❑	**Waiving Vision Coverage** ❑

Employee Signature	**Date Signed**

Complete Only if you are waiving Vision Insurance Coverage

The Group Vision Insurance Coverage available to me and my Dependents has been explained to me and I don't want to enroll. I decline Group Vision Insurance for:

____ Myself because I have dental insurance with ____________________Insurance Company.

___ My dependents because they have dental insurance with _______________________Insurance Company

Employee Signature ____Date_______________

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