EYE ASSOCIATES NETWORK

Enrollment Form

Effective Date: _____

New Enrollment ☐ Single ☐ Single + One ☐ Family **Change of Coverage** ☐ See Below

LAST NAME	FIRST NAME	MIDDLE

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER/GROUP NAME	DATE EMPLOYED	EMPLOYEE STATUS
		☐ FULL TIME ☐ PART TIME ☐ RETIREE

BIRTH DATE (MM/DD/YY)	SEX	SOCIAL SECURITY NO.	MARITAL STATUS
	☐ M ☐ F		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

NAME OF APPLICANT AND DEPENDENTS LAST NAME FIRST NAME MIDDLE	BIRTH DATE MM/DD/YY	SEX M F	FULL TIME STUDENT YES NO
APPLICANT **SELF** ☐ **YES** ☐ **NO**	**ABOVE**	**ABOVE**	
SPOUSE		☐ ☐	
DEPENDENT CHILDREN		☐ ☐	☐ ☐
		☐ ☐	☐ ☐
		☐ ☐	☐ ☐
		☐ ☐	☐ ☐
		☐ ☐	☐ ☐
		☐ ☐	☐ ☐

OTHER COVERAGE

DO YOU OR YOUR SPOUSE PRESENTLY HAVE OTHER VISION COVERAGE IN FORCE? ☐ YES ☐ NO

NAME OF POLICY HOLDER: _____ POLICY OR I.D. NUMBER: _____

NAME OF PLAN SPONSOR: _____ POLICY EFFECTIVE DATE: _____

NAME(S) OF COVERED PERSON(S): _____

COVERAGE CHANGES

Only complete the following if you are making changes to your existing Vision Plan Coverage with the **Eye Associates Network**.

EXISTING COVERAGE (CHECK ONE): ☐ SINGLE ☐ SINGLE + ONE ☐ FAMILY

CHANGE COVERAGE TO (CHECK ONE): ☐ SINGLE ☐ SINGLE + ONE ☐ FAMILY ☐ DROP, TERMINATION DATE _____

REASON FOR CHANGE (CHECK ALL THAT APPLY): ☐ ADDING SPOUSE - DATE OF MARRIAGE _____

☐ ADDING ELIGIBLE DEPENDENT CHILD(REN) ☐ OTHER _____

This is a Two Year Participating Vision Plan. Subject to the terms and conditions of plan, participating coverage will remain in effect for 24 months or until the next open enrollment period after 24 months, whichever is later. Rates may change on group renewal dates.

I certify that all the statements and answers in this application are complete and true to the best of my knowledge and belief. If applicable, I hereby authorize my employer to withhold the before-tax payroll deduction from my earnings pursuant to IRC Section 125 for payment of the premiums on this Vision Plan. I agree that if my employer does not offer an IRC Section 125 or if I terminate my employment, I will be individually liable for the payment for the Vision Plan for the two year term.

_____ _____

Enrollee Signature Date Authorized Signature Date