Vision Benefits of America (VBA)
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 ____

CHILD ____

EMPLOYEE SIGNATURE ___________________________ DATE _________________