



## Vision Service Plan Retiree Enrollment Form

☐ Enrollment form ☐ Waiver Form ☐ Change form

(Please indicate reason for change.)

☐ Name Change ☐ Address Change ☐ Change of employment status (Part-time to Full-time),  
☐ Termination ☐ Remove family members ☐ Add family members ☐ Return from Leave/Layoff  
☐ Marriage ☐ Birth ☐ Adoption - Specify date of Marriage/Birth/Adoption: \_\_\_\_\_  
☐ Court ordered dependent ☐ Other (describe) \_\_\_\_\_.)

Please PRINT clearly

Employee Name \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Hire \_\_\_\_\_ Requested Date of Coverage \_\_\_\_\_

### Complete if you wish to have coverage for your dependents

Enroll your spouse and dependent children below:

Last Name	First Name	Relationship To employee	Date of Birth	Social Security Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Dependents eligible for coverage under this plan are defined as:*

1. Legal spouse of a covered employee.
2. Unmarried children to age 19 provided such children are dependent upon the employee for support and maintenance. College-age children shall be covered provided they are full-time students until age 24.
3. Children of a covered employee who have attained the age specified in paragraph 2 above, who are incapable of self-sustained employment due to a handicap of disability, and who are still dependent on the employee.

I, \_\_\_\_\_, would like to enroll in this plan and authorize payroll deductions.

Signature \_\_\_\_\_ Date \_\_\_\_\_