

# INDIVIDUAL APPLICATION/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME		GROUP NO.		
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH	
STREET ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER — — — — —	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CONTRACT TYPE REQUESTED <input type="checkbox"/> Single <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Family <input type="checkbox"/> Limited Family (Parent/Child or Parent/Children)		
EFFECTIVE DATE OF COVERAGE OR CHANGE		DATE OF HIRE		

**COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE**

**PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES**

THIS CHANGE IS FOR:  EMPLOYEE  SPOUSE  DEPENDENT(S)

TYPE OF CHANGE:  NEW ENROLLMENT  CHANGE OF ADDRESS  NAME CHANGE  REINSTATEMENT

ISSUE CARD  CANCEL COVERAGE  NAME CHANGE, FORMERLY \_\_\_\_\_

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER SIGNATURE: **X** \_\_\_\_\_ DATE: \_\_\_\_\_



**NATIONAL VISION ADMINISTRATORS, LLC.**

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