

VISION BENEFITS OF AMERICA

City of Dover

ENROLLMENT FORM

VBA # 087

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 | _____ | _____ | _____ | ____ ____ _____ |

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED AS FULL-TIME COLLEGE STUDENTS.)

| STUDENTS NAME | NAME OF SCHOOL OR UNIVERSITY | BIRTHDATE |
|---------------|------------------------------|-----------------|
| _____ | _____ | ____ ____ _____ |
| _____ | _____ | ____ ____ _____ |

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME _____

EMPLOYEE SIGNATURE _____ DATE ____/____/_____

DECLINE COVERAGE