VBA Vision
Small Group
Enrollment Change Form

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EMPLOYER NAME:	**CLIENT ID #:**
EFFECTIVE DATE: _____ Enrollments effective the 1st day of the month Terminations effective the last day of the month	**VBA Plan (Select One)** ❑ Option 1 (009) ❑ Option 3 (2713) ❑ Option 2 (2712) ❑ Option 4 (4146)

EMPLOYEE INFORMATION

Last Name	**First Name**	**MI**	**Social Security**	
Address – Street		**New Address:** ☐ Yes ☐ No	**Date of Birth**	**Marital Status:** ☐ Single ☐ Married
Address – City State and Zip				
Home Phone:	**Work Phone**	**Email**	**Date of Hire**	**Gender:** ☐ Male ☐ Female

ENROLLMENT / CHANGE / TERMINATION INFORMATION

Covered Individual(s)						**Check Only One**		
	Last Name	**First Name**	**Gender**	**Date of Birth**	**Social Security Number**	**Add**	**Change**	**Term**
Employee	***Please indicate action to right for employee listed above***							
Spouse [A]			❒ Male ❒ Female					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					

[A] Includes Domestic Partners. Evidence of domestic partnership must be provided at time of enrollment.
[B] Dependent children may be covered until the end of the month attainment of age 26.

JUSTIFICATIONS / SIGNATURES

Justification: ❒ Open Enrollment
❒ Initial Eligibility
❒ Life Status Change Event (Explain Below)
❒ Other (Explain Below)
Explanation:

+Disability Effective Date: ____/____/_____
Reason: _____
_____
_____

EMPLOYEE SIGNATURE: _____ DATE ____/____/_____

EMPLOYER SIGNATURE: _____ DATE ____/____/_____