Enrollment / Change / Delete Form

Expert Solutions. Exceptional Service.

Please Note: Incomplete information may delay processing of this form (please print).
GROUP ADMINISTRATOR: Please return completed forms to:
VBA at Elig@vbaplans.com (Confirmation will be sent by VBA when this form has been processed).

This section to be completed by the Group Administrator:

Date: _____ Group#/Name: _____/_____ Subgroup (if applicable): _____

Administrator: _____ Phone #: _____ Ext: _____

Effective Date of Change: _____ Enrollment Status: _____ Active _____Cobra

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Employee Information Transaction Type: _____Add _____Change _____Delete

Social Security Number: _____ Date of Birth: _____ Gender: _____ Hire Date: _____

Employee Name: _____ Vision / Dental _____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

First Name, Middle Initial, Last Name — Action Codes: (A)dd (C)hange (D)elete

						VISION	DENTAL
SPOUSE:		SSN#	DOB:	GENDER	ACTION:		
CHILD 1:		SSN#	DOB:	GENDER	ACTION:		
CHILD 2:		SSN#	DOB:	GENDER	ACTION:		
CHILD 3:		SSN#	DOB:	GENDER	ACTION:		
CHILD 4:		SSN#	DOB:	GENDER	ACTION:		
CHILD 5:		SSN#	DOB:	GENDER	ACTION:		

Special Dependent Information – To be used to designate Full-Time Student or Handicapped Dependent

Child Name _____ Handicapped _____

Child Name _____ School _____

Child Name _____ School _____

I agree to all terms and conditions of the Vision and/or Dental Plan and corresponding payroll deductions (if applicable).

Employee Signature: _____ **Date:** _____

Reason for terminating coverage: _____