



**VISION BENEFITS OF AMERICA
ENROLLMENT FORM**

VBA#

SUBGROUP#

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

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY
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ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME

_____	_____	____ ____ ____
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EMPLOYEE SIGNATURE _____ DATE ____/____/____