VISION BENEFITS OF AMERICA **VBA# 2447** **SUBGROUP# ___________**

ENROLLMENT FORM

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: ___________________

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

	FIRST	MI	LAST	BIRTHDATE
SPOUSE/PARTNER				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____
CHILD				_____/_____/_____

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

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	
		_____/_____/_____
		_____/_____/_____

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME	
	_____/_____/_____

EMPLOYEE SIGNATURE: _____________________________ DATE: ____/_____/_____

INSTRUCTIONS FOR HR OFFICE:

1. MAIL ORIGINAL TO:

VISION BENEFITS OF AMERICA
300 WEYMAN PLAZA
PITTSBURGH, PA 15236