Vision Benefits of America, Inc.
Enrollment/Change/Terminate Form

Please note: Incomplete information may delay processing of this form.

400 Lydia St, Suite 300 Carnegie, PA 15106

THIS SECTION TO BE COMPLETED BY THE GROUP ADMINISTRATOR

DATE	GROUP NUMBER	SUB GROUP (IF APPLICABLE)
GROUP NAME		
ADMINISTRATOR	PHONE	EXT
EFFECTIVE DATE OF ENROLLMENT/TERMINATION OR CHANGE	ENROLLMENT STATUS ☐ ACTIVE ☐ COBRA	

EMPLOYEE INFORMATION

TRANSACTION TYPE ENROLL ☐ CHANGE ☐ TERMINATE ☐

NAME		
SOCIAL SECURITY NUMBER		DATE OF BIRTH
ADDRESS		
CITY	STATE	ZIP CODE

*DEPENDENT RELATIONSHIP: S=SPOUSE/DOMESTIC PARTNER, C=CHILD, H=HANDICAPPED CHILD, T=STUDENT

**ACTION CODES: (E)NROLL (C)HANGE (T)ERMINATE

DEPENDENT LAST NAME	DEPENDENT FIRST NAME	*DEPENDENT RELATIONSHIP	DATE OF BIRTH MM/DD/YYYY	**ACTION CODE
		S☐ C☐ H☐ T☐	/ /	
		S☐ C☐ H☐ T☐	/ /	
		S☐ C☐ H☐ T☐	/ /	
		S☐ C☐ H☐ T☐	/ /	
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		S☐ C☐ H☐ T☐	/ /	
		S☐ C☐ H☐ T☐	/ /	

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Employee Signature Date