



INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME Jefferson County Commission		GROUP NO. 8703 0000 01 <input type="checkbox"/> 8703 0000 99 <input type="checkbox"/> Cobra	
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER — — —	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Employee + 1 (L) <input type="checkbox"/> Family [Employee + 2 or more] (F)	
EFFECTIVE DATE OF COVERAGE OR CHANGE		DATE OF HIRE	

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: EMPLOYEE SPOUSE DEPENDENT(S)

TYPE OF CHANGE: NEW ENROLLMENT CHANGE OF ADDRESS NAME CHANGE REINSTATEMENT CHANGE TO COBRA

ISSUE CARD CANCEL COVERAGE NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____