VISION BENEFITS OF AMERICA **VBA# 615**
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE _____/_____/_____

INSTRUCTIONS FOR EMPLOYEE:
1. COMPLETE SECTION BELOW, SIGN AND RETURN TO 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
SPOUSE				
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 BENEFITS OFFICE:
1. MAIL THE ORIGINAL TO:

VISION BENEFITS OF AMERICA
300 WEYMAN PLAZA
PITTSBURGH PA 15236

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CHILD				____|_____|_____
CHILD				____|_____|_____
CHILD				____|_____|_____
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	____|_____|_____

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