



Synod of the Pacific
Vision Service Plan (VSP)
 Member Enrollment Form

<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> CHANGE ENROLLMENT	<i>Office Use Only</i>	
I. EMPLOYER INFORMATION		
Employer Name	Location	ZIP

II. EMPLOYEE INFORMATION					
Date of Hire	Date Full Time	COBRA Effective Date	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Marriage
Last Name		First	M.I.	Social Security Number	Sex (M/F)
Street Address		City	State	Zip	Home Phone Number ()
Occupation	Hours worked per week	Effective Date	Box A	Box B	Box C

III. OTHER HEALTH COVERAGE

Are you/your dependent(s) covered by another group Vision Plan? If so, please indicate carrier, insured's name and date of birth.

IV. Dependent Information:* (Required if dependent coverage is to be added or changed)						
Add/ Term	Full Name (Including middle initial)	Social Security No	Sex	Date of Birth	Relationship	FT Student
	Spouse					
	Dependent #1					
	Dependent #2					
	Dependent #3					
	Dependent #4					

V. WAIVER

The current benefits have been explained to me thoroughly. I DO NOT wish to enroll in the vision coverage for myself or my dependents.

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document, that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the dental plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my dental costs when in excess of the amounts payable under the plan.

SIGNATURE X _____ **DATE** _____

TO BE COMPLETED BY GROUP OR LOCATION ADMINISTRATOR ONLY

VII. REASON FOR THE ADD, CHANGE OR CANCELLATION

New Hire
 New Dependent
 Open Enrollment
 Termination
 Special Enrollment
 Other (Specify Below)

EMPLOYEE COVERAGE:

<input type="checkbox"/> Discharged	<input type="checkbox"/> Deceased: Date _____	<input type="checkbox"/> Last day worked: _____
<input type="checkbox"/> Retirement	<input type="checkbox"/> Resigned: Date Submitted _____	<input type="checkbox"/> Date of disability: _____
<input type="checkbox"/> Reduction of work hours	<input type="checkbox"/> Transfer from Location # _____ to# _____	<input type="checkbox"/> New Name: _____
<input type="checkbox"/> Increase of work hours	<input type="checkbox"/> New Address _____	<input type="checkbox"/> Other please specify: _____

DEPENDENT COVERAGE:

<input type="checkbox"/> Death of covered employee	<input type="checkbox"/> Date of divorce/legal Separation _____	<input type="checkbox"/> Eligible for Mediare
<input type="checkbox"/> No longer an eligible dependent	<input type="checkbox"/> Termination of dependent's health coverage	

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE	DATE
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