Voluntary Vision Insurance Enrollment / Change Form

EMPLOYER SECTION: FOR BENEFITS OFFICE USE ONLY		
Division: **TEAM 71061**	Employment Date:	Effective Date:

Select VSP vision care Coverage Option (See Rates section for monthly premiums)

☐ New Enrollment ☐ Waive / Drop Coverage ☐ Open Enrollment ☐ Special Enrollment

If Waiving Coverage, are you declining due to coverage under another plan? ☐ Yes ☐ No (if blank, will assume no)

If yes, is other coverage COBRA? ☐ Yes ☐ No

Employee's Name	Date of Birth (mm/dd/yy)	Social Security No.

U.S. Mailing Address	City	State	Zip

Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	Phone No.

Coverage Level: ☐ Employee Only ☐ Employee +1 ☐ Family

Discontinue coverage for: ☐ Employee and all dependents ☐ Only dependents listed below

COMPLETE THE FOLLOWING IF APPLYING FOR or DROPPING DEPENDENT COVERAGE (include last name if different)

Spouse Name	☐ Add ☐ Drop	☐ M ☐ F	SSN	Date of Birth (mm/dd/yy)
Dependent Name	☐ Add ☐ Drop	☐ M ☐ F	SSN	Date of Birth (mm/dd/yy)
Dependent Name	☐ Add ☐ Drop	☐ M ☐ F	SSN	Date of Birth (mm/dd/yy)
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Your employer has elected to deduct your vision insurance premiums on a pre-tax basis, unless written notification is received waiving this benefit.

____________________________ ____________________

Employee's Signature **Date**

Email to: *Benefits@TEAM.org*

Recv'd: ______________ Premiums: ______________ Website: ______________ OE: ______________ SF: ______________ APS:______________