

## Vision Plan Enrollment Form

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____
Group#: _____
Plan Variation Vision: _____
Reporting Code Vision: <u>GJ71</u>

Organization Name: HAMPSHIRE COLLEGE - 2012

I. Check the Appropriate Boxes					
<b>Coverage Desired</b> <input type="checkbox"/> Employee Only      \$4.63 <input type="checkbox"/> Employee + One      \$9.26 <input type="checkbox"/> Employee + Family      \$13.89		<b>REASON FOR CHANGE IN STATUS</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Status/Address <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Cancel Coverage			
HIRE DATE: _____		EFFECTIVE DATE: _____			
<b>II. Employee Information (please print clearly):</b>					
Unique Member ID Number _____ - _____ - _____ Birth Date ____/____/____ Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Gender <input type="checkbox"/> M / <input type="checkbox"/> F					
Your Name _____ (First) (Middle Initial) (Last)					
Address _____ _____ (City) (State) (Zip)					
III. List All Eligible Family Members Below (if electing dependent coverage):					
Relationship	First Name	Last Name	Birth Date	Full Time Student?	Gender
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.

**Florida Residents Only: NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_