



Vision Service Plan Employee Application

Print clearly using blue or black ink. Typed applications will not be accepted.

1. Enrollment Status

- New Group Enrollment
 Family Addition (Date of marriage, birth or adoption _____)
- COBRA or Cal-COBRA (Effective date _____)

2. Employee Information (Employee must complete this section)

Last Name		First Name		Middle Initial
Social Security Number		Hours Worked Per Week	Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed		<input type="checkbox"/> Married <input type="checkbox"/> Divorced		Number of Children
Applicant/Spouse Maiden Name		If spouse's last name is different from yours, please explain		
Home Street Address (P.O. Box not acceptable, unless Rural P.O. Box)			Apt. Number	
City	State	Zip	Home Phone	
Company Name		Job Title		
Business Phone		Date of Hire		

3. Member Information: List only yourself and those eligible family members who are enrolling.

An eligible dependent is an employee's lawful spouse, the unmarried children under age 19 of the employee or the employee's enrolled spouse, or the unmarried children of the employee or employee's enrolled spouse who are ages 19-24, full-time students, and fully dependent upon the employee for support.

	Last Name	First Name	M.I.	Birthdate	Covered by employer's Group Medical Policy?
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Authorization: (The following authorization section must be signed by all employees applying for coverage)

I understand that my employer is applying for membership to the Supplemental Vision Benefit Employer Trust (the "Trust") and I am simultaneously applying for insurance to which I am now or may be eligible for under the provisions of the Supplemental Vision Benefit Employer Trust issued to that Trust by Vision Service Plan. I understand that my insurance will not be in force until the application is approved by Vision Service Plan or their authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage.

I agree that all information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by BAC and Vision Service Plan.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I, the applicant, acknowledge that I have read and understand this application in its entirety.

Signature of Employee: _____ **Date:** _____