

Ameritas/VSP Vision Plan – Enrollment Form



Employee Name (Last, First, MI)				Employee Number	
<p>Please check one of the following:</p> <p><input type="checkbox"/> I AM ENROLLING MYSELF AND/OR MY DEPENDENTS IN THE AMERITAS/VSP VISION PLAN (CONTINUE TO FILL OUT FORM)</p> <p><input type="checkbox"/> I AM WAIVING ENROLLMENT FOR MY MYSELF/DEPENDENTS IN THE AMERITAS/VSP VISION PLAN OR I DO NOT WISH TO ENROLL AT THIS TIME. I MAY VOID THIS ELECTION FORM & CHOOSE TO ENROLL BY COMPLETING A NEW ENROLLMENT FORM WITHIN 60 DAYS OF MY HIRE DATE. (No other info needed) STOP HERE AND SIGN ON LINE BELOW:</p> <p>I DECLINE VISION COVERAGE: SIGN: _____ DATE: _____</p>					
Address: Street			City	State	Zip Code
Phone Number () -					
Emp. Date of Birth	Date of Hire	Marital Status	Sex	Social Security Number	
Mo Day Year	Mo Day Year	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Type of Enrollee: <input type="checkbox"/> New Hire Enrollment <input type="checkbox"/> Special Enrollee <input type="checkbox"/> Open Enrollment Reason: _____ Insurance Start Date: _____					
DEPENDENTS TO BE ENROLLED:					
Spouse Name (Last, First, MI)		Spouse SSN	Spouse Date of Birth	Spouse Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Date of Marriage: _____					
Dependent Child #1 Name (Last, First, MI)		Child SSN	Child Date of Birth	Child Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Dependent Child #2 Name (Last, First, MI)		Child SSN	Child Date of Birth	Child Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Dependent Child #3 Name (Last, First, MI)		Child SSN	Child Date of Birth	Child Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Dependent Child #4 Name (Last, First, MI)		Child SSN	Child Date of Birth	Child Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Are any dependent children adopted?	Yes	No	If yes, indicate name and date of placement		
Have you included stepchildren?	Yes	No	If yes, indicate names		
Are any dependent children adopted?	Yes	No	If yes, indicate name and date of placement		
Are the stepchildren dependent on you for support and maintenance?	Yes	No			
Choose Vision Plan :					
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee, Spouse, & Child(ren)		
<input type="checkbox"/> I hereby apply for the group benefit(s) indicated above. <input type="checkbox"/> I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined by the group plan) of full time service. <input type="checkbox"/> I authorize my employer to take deductions from my pay to cover the cost of my vision policy <input type="checkbox"/> The information provided above is true and correct to the best of my knowledge. <input type="checkbox"/> Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement may be guilty of insurance fraud. <input type="checkbox"/> I understand that I am allowed to use flexible pay for the purpose of qualified benefits as part of a flexible benefits plan under Section 125 of the Internal Revenue Code. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the vision coverage shown above. Such reductions, considered as elective contributions under the plan, shall commence with my first paycheck following the effective enrollment date. I further authorize future adjustments in the amount of the salary reduction in the event that the cost of coverage is changed during the plan year. I also understand that the purpose of this program is to allow employees to select this qualified benefit within the guidelines of the Internal Revenue Code. I also understand that this election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are in conjunction with a qualifying event, e.g.; marriage, divorce, death of a spouse or child, birth or adoption of a child and termination of employment of a spouse					
SIGNATURE OF EMPLOYEE			DATE SIGNED		