



Vision Benefits of America

Enrollment / Change / Delete Form

Please Note: Incomplete information may delay processing of this form.

Group Administrator: please return completed forms to: VBA at elig@visionbenefits.com or fax to 412-881-4898

This Section to be completed by the Group Administrator

Date: _____ Group #/Name: **1081 – Carlstadt Board of Education** Sub Group (If Applicable): _____

Administrator: _____ Phone #: _____ Ext: _____

Effective Date of Change: _____ Enrollment Status ___Active ___Cobra

Employee Information Transaction Type: ___Add ___Change ___Delete

Social Security Number: _____ Date of Birth: _____

Employee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

First Name, Middle Initial, Last Name Action Codes: (A)dd (C)hange (D)elete

Spouse:	_____	DOB:	_____	Action:	_____
Child 1:	_____	DOB:	_____	Action:	_____
Child 2:	_____	DOB:	_____	Action:	_____
Child 3:	_____	DOB:	_____	Action:	_____
Child 4:	_____	DOB:	_____	Action:	_____
Child 5:	_____	DOB:	_____	Action:	_____

Special Dependent Information - To be used to designate a Full-Time Student or Handicapped Dependent

Child Name	_____	Handicapped	_____
Child Name	_____	School	_____
Child Name	_____	School	_____

I agree to all terms and conditions of the VBA Vision Plan and corresponding payroll deductions (if applicable).

Employee Signature: _____ Date: _____