Enrollment / Change Form

SCHOOLCARE HEALTH BENEFIT PLANS

VSP Vision care for life

A

FOR EMPLOYER USE ONLY	Effective Date	Hire Date	Employer Name	Employer Address
☐ New Hire ☐ Open Enrollment	☐ Active ☐ Retiree ☐ COBRA	Account Number 3206140	Branch Code	Billing Group

Type of Change: See Qualifying Events on Reverse

☐ Address Change ☐ Add Dependent(s): List names in Section B ☐ Retirement

☐ Cancel Employee* ☐ Cancel Dependent(s)*_____ ☐ Other: _____

**Must also complete COBRA Notification Request Form*

B

Employee Name *(last)*	*(first)*	*(M.I.)*	Social Security #
Cell Phone	Home Phone	E-Mail Address	
Mailing Address *(Street, Apt #, or PO Box)*	*(City)*	*(State)*	*(Zip Code)*

Last Name / First Name / M.I.	Plan	Social Security #	Date of Birth	Gender	Relationship to Subscriber (i.e. legally married, *domestic partner, biological, step or adopted child (*not all Employers offer DP coverage))
Employee	☐ Vision	| |	| |	☐ M ☐ F	Spouse E-mail Address
Spouse (whom you wish to cover)	☐ Vision	| |	| |	☐ M ☐ F	☐ Legally Married ☐ Domestic Partner*
Dependent (whom you wish to cover)	☐ Vision	| |	| |	☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)	☐ Vision	| |	| |	☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)	☐ Vision	| |	| |	☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted

C

VSP Vision care for life

Choice Vision Plan

VSP Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details

If declining coverage, please initial below.

_____ **Decline Vision Coverage**

D

Other Health Care Coverage

Will you or your covered dependents have other health insurance while on SCHOOLCARE? ☐ Yes ☐ No

Name of person covered	ID Number or Medicare No.	Effective Date	Name of Carrier	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
1.				☐	☐	☐	☐
2.				☐	☐	☐	☐

Signature – The information provided above is true and correct to the best of my knowledge.

E

Employee's Signature/ Date	Employer's Signature / Date

Please make a copy for both employee and employer then submit the original to SCHOOLCARE.

Please review additional information on reverse side of this form.