VBA® – We Help America Stay Healthy and See Clearly!

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: **3860 State College Area School District** Sub Group (If Applicable):

Administrator: _____ Phone #:_____ Ext: _____

Effective Date of Change: _____ Enrollment Status ____Active ___Cobra

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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: _____