MADISON ONEIDA HERK HEALTH CARE CONS.

Instructions

1. You must enroll using this form before you or a family member can begin to use this vision benefit. No enrollment fee is required. Failure to enroll may result in delays when you or a family member need vision care services in the future.

2. For new or changed enrollments, you must complete all information requested on eligible dependents.

3. To change your address, please include your name, Social Security number, and new address. Mark the check box below to indicate an address change.

4. To enroll a dependent, include their name, date of birth, and relationship. For relationship, use the following codes: **W=Wife, H=Husband, S=Son, D=Daughter, P=Domestic Partner (if applicable).**

5. You **may** or **may not:**

   - be able to be covered as both a member and as a dependent of a member, if both you and your spouse are employed by the same company or bargaining unit

   - be required to enroll for a specified minimum time period.

   Please verify this information with your benefit office.

Member\Employee Name: _____ **Social Security #:** _____ (REQUIRED)

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ **Employer:** _____

Is the address listed above new? ☐ **Yes** ☐ **No** Daytime Phone Number: ( ) _____

Is this the first time you have enrolled in the Vision Care Plan or are you changing an existing enrollment record? (Complete all dependent information below if checking either box):

☐ **New Enrollment** ☐ **Change**

**** PLEASE NOTE: All information above must be completed in order to process your enrollment. ****

"I certify that this enrollment information is true and correct."

_____ _____

Member/Employee Signature Date

List All Eligible Dependents Below

Last Name (if different from member)	First	M.I.	Rel.	Date of Birth	M/F