INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME Chesterfield Twp Board of Education			GROUP NO. 4246 0000 01
EMPLOYEE LAST NAME	**FIRST**	**MI**	**DATE OF BIRTH**

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER __ __	GENDER ☐ Male ☐ Female	CONTRACT TYPE REQUESTED ☐ Single (S) ☐ Employee + Spouse (L) ☐ Employee + Child(ren) (E) ☐ Family [Employee, Spouse, Child(ren)] (F)

EFFECTIVE DATE OF COVERAGE *OR* CHANGE	DATE OF HIRE

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.
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Clifton, NJ 07013

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