



# INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE  
(Please Print or Type)

EMPLOYER (GROUP) NAME Grand Blanc Community Schools		GROUP NO. 3309 0000 01 <input type="checkbox"/> 3309 0000 99 <input type="checkbox"/> Cobra	
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH
STREET ADDRESS		CITY	STATE ZIP
SOCIAL SECURITY NUMBER — — —	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Employee + 1 (L) <input type="checkbox"/> Family [Employee + 2 or more] (F)	
EFFECTIVE DATE OF COVERAGE OR CHANGE 01/01/2025		DATE OF HIRE open enrollment	

**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

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