



Voluntary Vision Care Enrollment Form

Name (Last, First, Middle Initial)

Home Address

City

State

Zip

Date of Birth

Home Phone

Social Security Number

Please Indicate Coverage Type:

☐ Individual

☐ Family

If you are electing family coverage, list below the names of spouse/domestic partner and/or children under 26 years of age. Adult children are covered to the end of the calendar year in which the child attains the age of 26. Unmarried children older than 26 years of age, who are incapable of self-support because of mental or physical disability, are covered if medical documentation of the disability is provided and upon approval from the Plan Administrator.

First Name	MI	Last Name (if different)	Relationship	Date of Birth

Signature. *I certify that this information is true and correct.*

Date

Note: Members are responsible for notifying the Plan Office of any changes in marital/domestic partner or dependent status. Members who defraud or attempt to defraud the NYSUT Member Benefits Trust-endorsed Voluntary Vision Plan or who knowingly give false or misleading information are subject to a penalty, which may include, but may not be limited to, suspension of eligibility for all Plan benefits.