Vision Insurance Plan of America, Inc.

ENROLLMENT FORM

Employer: COUNCIL FOR THE SPANISH SPEAKING Dept/Location: _____

Date of Hire: _____ Effective Date: _____

Employee Name: _____
First M.I. Last

Employee Soc. Sec. # _____-_____-_____ Sex: Y M Y F

Employee Birthdate: _____/_____/_____ Home Phone: (_____)_____

Home Address: _____

City: _____ State: _____ Zip: _____

COVERAGE: YSINGLE YLIMITED FAMILY (employee + spouse or employee + child or children) YFAMILY

PLAN: YFULL SERVICE (exam & materials) YMATERIALS ONLY YEXAM ONLY YWAIVE

COVERED DEPENDENTS

NAME	BIRTHDATE	RELATIONSHIP	SOC. SEC. #
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -

EMPLOYEE SIGNATURE: _____ DATE: _____

IN ORDER FOR US TO PROPERLY ENTER YOU INTO OUR COMPUTERS, WE NEED ALL INFORMATION ON THIS FORM FILLED OUT AT TIME OF ENROLLMENT. THANK YOU.

Vision Insurance Plan of America, Inc.
PO Box 44077
West Allis, WI 53214
800-883-5747 Fax:414-475-1599

VISION INSURANCE PLAN OF AMERICA, INC.

P.O. Box 44077
Milwaukee, WI 53214-7077
(414) 475-1875 (800) 883-5747 Fax (414) 475-1599

CHANGE OF STATUS

Date _____ COUNCIL FOR THE

Plan Number 214330 **Group Name** SPANISH SPEAKING

Employee Name: _____ **Soc. Sec.** _____

CHANGE OF ADDRESS

New Address:

Street Address _____ **Apt #** _____

City _____ **State** _____ **Zip Code** _____

New Phone #: _____

NAME CHANGE

New Name: _____

_____ **ADDING DEPENDENTS** _____ **DELETING DEPENDENTS**

- ☐ **Spouse** **Reason:** _____
- ☐ **Child** **Effective Date:** _____

Name _____ **DOB** _____ **Soc. Sec. #** _____

Name _____ **DOB** _____ **Soc. Sec. #** _____

COBRA COVERAGE

_____ **Electing Cobra Coverage**

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* Please fill out all areas that apply

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