Group Name: Nonprofit Resources **Group # 12065657**

VISION SERVICE PLAN ENROLLMENT/CHANGE OF STATUS FORM

______________________________	______________________________
EMPLOYER NAME (Required)	**EFFECTIVE DATE (Required)**

____________	____________	______	______	__________
Employee's Last Name	**First Name**	**M.I.**	**DOB**	**Social Security #**
____________	____________	______	______	__________
Spouse's Last Name	First Name	M.I.	DOB	Social Security #

(Children)	Last Name	First Name	M.I.	DOB
1.				
2.				
3.				
4.				
5.				
6.				

☐ **NEW ENROLLMENT** **HIRE DATE:** ______________________________

I hearby authorize and direct my employer to deduct from my salary each month the amount of monthly vision premium, as required, to be paid by me and to remit the same to Nonprofit Resources, Inc.

Plan Type: **Plan C** ☐ (12-month) **Plan A** ☐ (24-month)

☐ **CHANGE OF STATUS**

If this form is being completed to change information previously submitted, please check one of the following:

☐ Addition of Dependents
- ☐ Birth Date __________
- ☐ Marriage Date __________
- ☐ Other ____________________

☐ Deletion of Dependents
- ☐ Death
- ☐ Divorce
- ☐ Child not eligible because of age

☐ Correction of an error ____

☐ **TERMINATION OF COVERAGE**

If coverage is being terminated, please check one of the following:

☐ Termination of Employment Date:_______________

☐ COBRA (If member would like to continue) Date: _______________

☐ Other____

The information on this form is complete and accurate.

______________________________	____________________
Employee Signature	Date

VSPenrollmentform.doc