Vision Plan Enrollment / Change Form

OFFICE USE ONLY:	
Approval	_____
Effective Date	_____
Keyed	_____

_____
Name Employee ID#

_____
Address

_____
City State Zip

_____ ____ Monthly ____ Biweekly ____ Retiree ____ COBRA
Date of Birth Phone number

1. _____ **New Enrollment** Complete Sections 2, 3, 4, & 5 _____ **Add / Drop Dependent (circle one)** Complete Sections 2, 3, 4, & 5 _____ **Decline / Cancel Plan (circle one)** Complete Sections 2 & 6

2. **Qualifying event:** Please **circle one** and print **date** of the event.

__/__/__ New Employee __/__/__ Birth* or Adoption* (circle one) __/__/__ Marriage* or Divorce* (circle one)

__/__/__ Loss or gain of vision coverage* (circle one) __/__/__ Other* _____

**Supporting Documentation will be required before processing.*

3. **Select your coverage level:**

_____ **Employee Only** _____ **Employee/Child(ren)** _____ **Employee/Spouse** _____ **Employee/Family**

4. **Dependent Information:** Employees are required to supply *supporting documentation* and/or *additional forms* for stepchildren and/or other dependents with different last names.

	Relationship	Dependent Name	Sex	Date of Birth	Social Security # {Required}
____ Add ____Drop	Spouse				
____ Add ____Drop	Child				
____ Add ____Drop	Child				
____ Add ____Drop	Child				

5. **Acceptance/Certification:**
I hereby request to be a participant under the NEISD Vision Plan. I understand that no benefit will become effective until the latest of the effective date of the plan or the date on which I satisfy the minimum service requirement as stated in the plan document. I hereby authorize my employer to make necessary payroll deductions from my paycheck, if any are required. I reserve the right to revoke the payroll deduction authorization during the annual NEISD Open Enrollment period. All NEISD forms and supporting documentation must be received in the Employee Benefits office within 31 days from, and including, your qualifying event date.

I hereby certify that the above information is correct. I also understand that I must notify Employee Benefits within 31 calendar days if any dependent ceases to be eligible.

_____ _____ _____
Employee Signature Date Campus/Department

6. **Declination or Cancellation of Benefit:**
After careful consideration, I have decided NOT to participate in or cancel the vision plan benefit and waive my rights to such benefit.

_____ _____ _____
Employee Signature Date Campus/Department