

# Vision Service Plan Membership Enrollment Form



TYPE OR PRINT INFORMATION

**1** Name (Last, First, Middle Initial)

|           |           |                        |                          |
|-----------|-----------|------------------------|--------------------------|
| Mail Stop | Telephone | Social Security Number | Date of Birth (mm/dd/yy) |
|-----------|-----------|------------------------|--------------------------|

**2** Enrollment  Self  Family

**3** Please list all of your dependents (under family coverage)

| Last Name  | First Name | MI | Social Security Number | Date of Birth (MM/DD/YY) |
|--|------------|----|------------------------|--------------------------|
| Spouse   |            |    |                        |                          |
| Domestic Partner   |            |    |                        |                          |
| Children (include surname, if different)(Social Security Numbers MUST be included) |            |    |                        |                          |
|  |            |    |                        |                          |
|  |            |    |                        |                          |
|  |            |    |                        |                          |
|  |            |    |                        |                          |

**PLEASE RETURN THIS FORM TO HUMAN RESOURCES, MAIL STOP 146.**

**4** I authorize payroll deduction from my earnings to pay my premium.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**5**  I elect to cancel my present enrollment.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**(FOR HR USE ONLY)**

**6**  New Hire  Open Season  Change in marital/family status  Separation/Retirement

Effective date of coverage \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ Effective date of coverage \_\_\_\_\_

**7** I certify that the above named employee is eligible for coverage.

Signature (authorized agency official) \_\_\_\_\_ Date of receipt \_\_\_\_\_ PeopleSoft Code \_\_\_\_\_

Remarks

**PRIVACY ACT STATEMENT**

The information you provided on this form is needed to document in your personnel, payroll and/or retirement records file your enrollment in the Group Health Insurance Program. This information will be shared with the health insurance carrier, CIGNA, so that they may (1) identify your enrollment in their plan, (2) verify your and/or your family eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with who you might also make a claim for payment of benefits. This information may also be disclosed to other Federal agencies or Congressional offices which have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their

programs. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared with an appropriate Federal, state, or local law enforcement agency. Executive Order 9397 dated November 22, 1943 authorizes the use of the Social Security Number to distinguish you and people with similar names. Maintenance of this information is authorized by Section 9 and 10 of the Federal Deposit Insurance Act (12 USC 1819 and 1820), by Section 10 of the Federal Reserve Act (12 USC 244), and by the National Banking Act (12 USC 481). Furnishing your Social Security Number, as well as other data, is voluntary, but failure to do so may result in the inability to obtain health insurance coverage.