

NMR Vision Care Plans Employee Enrollment

<input type="checkbox"/> New Enrollment	Change: <input type="checkbox"/> Address <input type="checkbox"/> Name <input type="checkbox"/> Dependent addition	Termination: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Group Number	Effective Date
Reason for change or termination:				

Employee

Group Name	Date of Hire	Location or Branch	Employee Class	Hours per Week
Name (Last, First MI)		Date of Birth	Social Security Number	
Street Address		City	State	Zip
Home Phone Number	Email Address	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Date of Marriage

Dependents: add waive for cost waive for other coverage

Spouse	Name (Last, First MI)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Relation	Disabled?
Children		<input type="checkbox"/> Male <input type="checkbox"/> Female			Y / N
		<input type="checkbox"/> Male <input type="checkbox"/> Female			Y / N
		<input type="checkbox"/> Male <input type="checkbox"/> Female			Y / N
		<input type="checkbox"/> Male <input type="checkbox"/> Female			Y / N
		<input type="checkbox"/> Male <input type="checkbox"/> Female			Y / N

I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms in the group contract.

Signature _____ Date _____

COBRA

Qualifying COBRA Event:	<input type="checkbox"/> Termination	<input type="checkbox"/> Widowed	<input type="checkbox"/> Overage Dependent	Qualifying Date
	<input type="checkbox"/> Retirement	<input type="checkbox"/> Surviving Dependent	<input type="checkbox"/> Legal Separation	Social Security Number
	<input type="checkbox"/> Reduction in hrs.	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Divorced			

I understand that I may be required by the employer to pay for these benefits.

Signature _____ Date _____

