Vision Benefits of America
Enrollment / Change / Delete Form

Please Note: Incomplete information may delay processing of this form.

This Section to be Completed by the Group Administrator

Date: _____ Group #: _____ Sub Group (If Applicable): _____

Group Name: _____

Administrator: _____ Phone #: _____ Ext: _____

Effective Date: _____ Enrollment Status ☐ Active ☐ Cobra

Employee Information Transaction Type: ☐ Add ☐ Change ☐ Delete

Name: _____ Social: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

First Name, Middle Initial, Last Name Action Codes: (A)dd (C)hange (D)elete

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Spouse: _____ DOB: _____ Action: ____

Child 1: _____ DOB: _____ Action: ____

Child 2: _____ DOB: _____ Action: ____

Child 3: _____ DOB: _____ Action: ____

Child 4: _____ DOB: _____ Action: ____

Child 5: _____ DOB: _____ Action: ____

Special Dependent Information - To be used to designate a Full-Time Student or Handicapped Dependent

Child Name _____ Handicapped ☐

Child Name _____ School _____

Child Name _____ School _____

I agree to all terms and conditions of the VBA Vision Plan and corresponding payroll deductions (if applicable).

Employee Signature: _____ Date: _____