Vision Plan

For Employees of City of Goldsboro

Employee Name: _____

Date of Birth: _____ Gender: _____ Telephone _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Coverage Type

☐ Employee Only	$2.97	Bi-weekly
☐ Employee + One	$5.94	Bi-weekly
☐ Employee + Family	$9.12	Bi-weekly

☐ I do not wish to participate in the vision plan.

Family Members (please list if enrolling for Employee + Child(ren), Spouse or Family)

Name	Relationship	Date of Birth	Gender	Add	Term
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐

I hereby apply for enrollment in the Community Eye Care Vision Plan for a minimum of twelve (12) months (or until the beginning of the next plan year). I authorize my employer to deduct the membership fees from my earnings. I also authorize any changes or terminations listed above.

_____ _____

Employee Signature Date

FOR BENEFITS MANAGERS USE ONLY

☐ **NEW ENROLLMENT** Benefit Effective Date _____ Employee ID # _____ *(please do not use Social Security #s)*

☐ **CHANGE REQUESTED** (*Check all that apply)* ☐ Reinstate Coverage ☐Name ☐ Address ☐ Telephone ☐Group Plan ☐ Add/Remove Dependent(s)

Effective Date of Change _____ Reason_____

☐ TERMINATION Effective Date of Termination_____ Reason_____

Reason Descriptions: OE (Open Enrollment) QE (Qualifying Event) NLE (No Longer Employed) RT (Retired) LOA (Leave of Absence) DE (Deceased)