mesvision

# VISION PLAN ENROLLMENT/CHANGE REQUEST

| Employee Effective Date: |
|---|

## EMPLOYEE INFORMATION

| Current Last Name | First Name | MI |
|---|---|---|
| | | |

| Address | Employee ID Number/Social Security Number | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

| City | State | Zip Code | Date of Hire |
|---|---|---|---|
| | | | |

| Group Name | MES Group Number |
|---|---|
| | |

## PLEASE ENROLL/CHANGE MY PLAN AS INDICATED

New Enrollee  Add dependent(s)  Delete dependent(s)  If adding spouse, give marriage date:

Eligible dependents are your spouse and unmarried children within the ages stated in your evidence of coverage.
Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the MESVision evidence of coverage.

☐ Change my name as shown. My former name is:

## LIST BELOW ALL DEPENDENTS

| ☐ Effective Date | Change | Relationship | Sex | First Name | MI | Last Name | Date of Birth (mm/dd/yyyy) | Full-time Student? |
|---|---|---|---|---|---|---|---|---|
| | Enroll Add Del | | | | | | | Yes No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |
| | ☐ Enroll ☐ Add ☐ Del | | | | | | | ☐ Yes ☐ No |

SIGNATURE:_____ DATE: _____

**PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER**

**NOTE TO GROUP ADMINISTRATORS**

Submit this form to Medical Eye Services for initial group enrollment only. All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.