Vision Benefits of America

Enrollment / Change / Delete Form

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

Group Administrator: please return completed forms to: VBA at elig@visionbenefits.com or fax to 412-881-4898

This Section to be completed by the Group Administrator

Date: __________ Group #/Name: 3672 Wallingford Swarthmore SD Sub Group (If Applicable):

Administrator: ____________________________________ Phone #:_________________ Ext: ______

Effective Date of Change: ________________________ Enrollment Status ____Active ___Cobra

---

Employee Information Transaction Type: ____Add ____Change ____Delete

Social Security Number: ________________________ Date of Birth: ___________________________

Employee Name: ____

Address: ____

City: ________________________________ State: _______ Zip Code: ____________

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

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: ____________