

Employee ID \_\_\_\_\_



### VOLUNTARY VISION ENROLLMENT/CHANGE FORM

Effective Date of Coverage: \_\_\_\_\_

Name of group: University of Vermont

Employee (last name, first name, middle initial): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_

Reason for Change:

- New Hire
- Re-Hire
- Open Enrollment
- COBRA\*
- Change of Dependents
- Waive/Cancel

Type of coverage selected (Premiums/Month):

- Employee \$7.26
- Employee + Spouse \$14.51
- Employee + Child(ren) \$13.68
- Family \$22.77
- COBRA \_\_\_\_\_

Dependent Last Name	Dependent First Name	Relationship (Spouse, Child)	Date of Birth MM/DD/YYYY	Add / Delete
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_