Send completed forms to Human Resources via uvm.edu/filetransfer to HRinfo@uvm.edu.

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: _____

Updated 10/2023

*COBRA Premiums are found in letter offering coverage