



**VISION BY DESIGN ONLY
GROUP ENROLLMENT, WAIVER,
AND CHANGE REQUEST FORM**



9725 E Hampden Avenue #400
Denver, CO 80231
1-800-807-0706 (Phone)
303-744-2890 (Fax)

- New Employee Change Address
 COBRA Change Dependent Status
 Terminate Coverage*

* Can only terminate coverage at open enrollment or if employment is terminated.

TO BE COMPLETED BY EMPLOYER	Companion Group No.	Div.	Class
Name of Employer (Use Name from Group Billing Notice or Master Application)			

TO BE COMPLETED BY EMPLOYEES ELECTING TO ENROLL												
Social Security Number			Effective Date			Date Employed Full Time			Date of Birth			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	Month	Day	Year	
Your Name Last		First				M.I.		Sex				
								<input type="checkbox"/> Female <input type="checkbox"/> Male				
Marital Status	Your Home Address					City		State		Zip Code		
<input type="checkbox"/> Single <input type="checkbox"/> Married												

Vision by Design Only (check the correct box)

Vision Select

COMPLETE FOR VISION					
Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Coverage Is For (Check Box Below):				Are you or any of your dependents covered for vision insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus 1	<input type="checkbox"/> Employee plus 2	<input type="checkbox"/> Employee plus 3 or more	

Complete for Dependent Coverage			Full-time	Date of Birth	Gender	Do any of your dependents have any other vision coverage?	If Yes, Name of Carrier
Spouse Name	(Last)	(First)	Student Y/N	/ /	M or F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		(Middle Initial)		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
C H I L D R E N	1			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	6			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

WAIVER OF COVERAGE

I have been offered the above plan and decline to purchase this plan at this time. I understand that in the event I desire such benefits at a later date, the company will have the right to refuse any request.

Coverage Refused: Vision

Date _____ Signature of Employee _____

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the plan, then I authorize my employer to deduct the contribution from my wages.

Date	Your Signature
	X