

# VISION SERVICE PLAN

## COBRA

ENROLLMENT / CHANGE / TERMINATION FORM

(PLEASE PRINT)

EMPLOYEE NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**This is a(n):**

- Enrollment (Initial COBRA Enrollment or Open Enrollment)
- Change (addition or deletion of dependents)
- Termination (cancellation of coverage)

**COVERAGE LEVEL (PLEASE CHECK ONE):**

- EMPLOYEE ONLY
- EMPLOYEE + SPOUSE
- EMPLOYEE + CHILD (REN)
- EMPLOYEE + FAMILY

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**GROUP NUMBER: 12103137**  
**DIVISION NUMBER: 0001**