VISION CARE ENROLLMENT FORM

MOH HEALTH CARE CONSORTIUM **New** **Change** **Terminate**

Effective Date: ______________________________

Instructions:

1. You must enroll using this form before you or a family member can begin to use this vision benefit. No enrollment fee is required. Failure to enroll may result in delays when you or a family member need vision care services in the future.
2. For new or changed enrollments, you must complete all information requested on eligible dependents.
3. To change your address, please include your name, Social Security number, and new address. Mark the box below to indicate an address change.
4. To enroll a dependent, include their name, date of birth and relationship. For relationship, use the following codes:

   H = Husband W = Wife S = Son D=Daughter P= Domestic Partner (if applicable)

5. You may not be able to be covered as both a member and as a dependent of a member, if both you and your spouse are employed by the same company or bargaining unit.
6. You may be required to enroll for a specified minimum time period.

Please verify this information with your benefit office.

Member/Employee Name:

Social Security #:

Address:

Date of Birth:

City/State/Zip:

Employer: **MECS**

Is the address listed above new? ☐ Yes ☐ No

Daytime Phone Number:

List all Eligible Dependents Below:

Last Name (if different from member)	First	M. I.	Rel.	DOB:	M/F

"I certify that this enrollment information is true and correct."

______________________________ ______________________________

Member/Employee Signature Date