# INDIVIDUAL APPLICATION/CHANGE FORM

**FOR VISION COVERAGE**

(Please Print or Type)

| **EMPLOYER (GROUP) NAME** | | | **GROUP NO.** |
|---|---|---|---|
| **EMPLOYEE LAST NAME** | **FIRST** | **MI** | **DATE OF BIRTH** |
| **STREET ADDRESS** | **CITY** | **STATE** | **ZIP** |
| **SOCIAL SECURITY NUMBER** ___ ___ | **GENDER** ☐ Male ☐ Female | **CONTRACT TYPE REQUESTED** ☐ Single ☐ Employee/Spouse ☐ Family ☐ Limited Family (Parent/Child or Parent/Children) | |
| **EFFECTIVE DATE OF COVERAGE *OR* CHANGE** (1st of the month only) | | **DATE OF HIRE** | |

**COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE**

**PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES**

**THIS CHANGE IS FOR:** ☐ **EMPLOYEE** ☐ **SPOUSE** ☐ **DEPENDENT(S)**

**TYPE OF CHANGE:** ☐ **NEW ENROLLMENT** ☐ **CHANGE OF ADDRESS** ☐ **NAME CHANGE** ☐ **REINSTATEMENT**

☐ **ISSUE CARD** ☐ **CANCEL COVERAGE** ☐ **NAME CHANGE, FORMERLY** _____

| LAST NAME | FIRST NAME | INITIAL | M / F | DATE OF BIRTH | STUDENT (Y/N) |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____

**NATIONAL VISION ADMINISTRATORS, LLC.**
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