



Vision Benefits of America

Enrollment / Change / Delete Form

Please Note: Incomplete information may delay processing of this form.
Completed forms return to: VBA at elig@visionbenefits.com or fax to 412-881-4898

This Section to be completed by the Group Administrator

Date: _____ Group #: _____ Sub Group (If Applicable): _____

Group Name: _____

Administrator: _____ Phone #: _____ Ext: _____

Effective Date of Change: _____ Enrollment Status Active Cobra

Employee Information Transaction Type: Add Change Delete

Social Security Number: _____ Date of Birth: _____

Employee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

First Name, Middle Initial, Last Name Action Codes: (A)dd (C)hange (D)elete

Spouse: _____ DOB: _____ Action: _____

Child 1: _____ DOB: _____ Action: _____

Child 2: _____ DOB: _____ Action: _____

Child 3: _____ DOB: _____ Action: _____

Child 4: _____ DOB: _____ Action: _____

Child 5: _____ DOB: _____ Action: _____

Special Dependent Information - To be used to designate a Full-Time Student or Handicapped Dependent

Child Name _____ Handicapped

Child Name _____ School _____

Child Name _____ School _____

I agree to all terms and conditions of the VBA Vision Plan and corresponding payroll deductions (if applicable).

Employee Signature: _____ Date: _____