EyeMed
The Eye Care Plan of America℠

FPPA EyeMed Vision Care Plan

- ❑ **Enrollment form**
- ❑ **Waiver Form**
- ❑ **Change form (Please indicate reason for change. __ Name Change__Address Change__Change of employment status (Part-time to Full-time)___Remove family members __Add family members___Return from Leave/Layoff__Marriage__Birth__Adoption__Court ordered dependent__Other (describe)____________________________.)**

Please **PRINT** clearly

Employee Name______________________________ __________________________________ _____________
Last First Initial

Address____City_________________State_____ Zip_________

Telephone # (_______) ______-__________ Social Security # _________________________ Date of Birth_______________

Date of Hire _____________________________Requested Date of Coverage_____________________________

Plan Election: (Check only one)

- ❑ Preferred
- ❑ Premier

Complete if you wish to have coverage for your dependents

Enroll your spouse and dependent children below:

Last Name	First Name	Relationship To employee	Date of Birth	Social Security Number

Dependents eligible for coverage under this plan are defined as:

1. Legal spouse of a covered employee.
2. Unmarried children to age 19 provided such children are dependent upon the employee for support and maintenance. College-age children shall be covered provided they are full-time students until age 24.
3. Children of a covered employee who have attained the age specified in paragraph 2 above, who are incapable of self-sustained employment due to a handicap of disability, and who are still dependent on the employee.

I, _______________________________________, would like to enroll in this plan and authorize payroll deductions.

Signature____ Date_______________________

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WAIVER

I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:

___ Existence of other health coverage

___Spousal coverage

___Other reason (explain)____.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, I may apply at the next open-enrollment period. I may in the future be able to enroll my self or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Employee Signature________________________________ Date Signed ______________________________
(only sign if you are waiving coverage)

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