



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 _____



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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