COMMUNITY EYE CARE

VISION PLAN

FOR EMPLOYEES OF MARS HILL UNIVERSITY

Employee: _____ **Benefit Effective Date:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ ☐ **Male** ☐ **Female**

Date of Birth: _____ **ID #** _____

ENROLLMENT

☐ **Employee Only**	**$6.20**	**Monthly**
☐ **Employee + Spouse**	**$11.44**	**Monthly**
☐ **Employee + Child(ren)**	**$11.98**	**Monthly**
☐ **Employee + Family**	**$17.94**	**Monthly**

☐ I DO NOT WISH TO PARTICIPATE IN THE VISION PLAN.

FAMILY MEMBERS *(Please list if enrolling for* **Employee + Child(ren), Spouse or Family***)*

Name	Relationship	Date of Birth	Gender

☐ **ENROLLMENT** *(New Members)*

☐ **CHANGE REQUESTED** *(Check all that apply):* ☐ **Name** ☐ **Address** ☐ **Telephone** *(Enter each change in main body of form)*

☐ **Add Dependent(s)** *(List additions under Family Members above)*
Reason and Effective Date of Change: _____

☐ **Cancel Dependent(s)** *(List dependents to be cancelled under Family Members above)*
Reason and Effective Date of Change: _____

☐ **TERMINATION** Reason and Effective Date of Employee Termination: _____

I hereby apply for enrollment in the Community Eye Care Vision Plan for a minimum of twelve (12) months (or until the beginning of the next plan year). I authorize my employer to deduct the membership fees from my earnings. I also authorize any changes or terminations listed above.

_____ _____

Employee Signature *Date*