



INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME Trustees Insurance Fund -			GROUP NO.		
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH		
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Employee + Spouse (L) <input type="checkbox"/> Employee + Child(ren) (E) <input type="checkbox"/> Family [Employee, Spouse, Child(ren)] (F)			
EFFECTIVE DATE OF COVERAGE OR CHANGE			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 CHANGE TO COBRA

ISSUE CARD CANCEL COVERAGE NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	COLLEGE STUDENT (Y/N)
Spouse					
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: _____

www.e-nva.com

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