INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER: Hudson County Community College			GROUP NO: 4079 0000 01-99
LAST NAME:	**FIRST NAME:**	**MI**	**DATE OF BIRTH**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**

SOCIAL SECURITY NUMBER	GENDER	CONTRACT TYPE REQUESTED
— —	☐ Male ☐ Female	☐ Single *$5.15* ☐ Employee + Spouse *$10.30* ☐ Employee + Child(ren) *$16.48* ☐ Family (Employee, Spouse, Child(ren)*$19.57*

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	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

NATIONAL VISION ADMINISTRATORS, L.L.C.
1200 Route 46 West
Clifton, NJ 07013

Toll Free: (800) 672-7723

This document has been printed on recycled paper.