



INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER: Hudson County Community College		GROUP NO: <u>4079 0000 01-99</u>	
LAST NAME:	FIRST NAME:	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 \$5.30 <input type="checkbox"/> Employee + Spouse \$10.61 <input type="checkbox"/> Employee + Child(ren) \$16.97 <input type="checkbox"/> Family (Employee, Spouse, Child(ren)) \$20.16	
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.

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Clifton, NJ 07013

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