VSP Eye Care Health Plan

Enrollment Form

Group Name: Napa Valley College

A ENROLLEE (Complete this section for new enrollment or change of status)

Name

Last First Middle Initial

Social Security Number

__________-_______-__________

(Member I.D. Number

Action Requested

❒ New enrollment
❒ COBRA enrollment
❒ Change in enrollment
❒ Reinstatement

Birthdate

_____/_____/_____
Month Day Year

Sex

❒ Male
❒ Female

Classification

❒ Certificated
❒ Classified
❒ CDC
❒ COBRA

Mailing Address

Street number or PO box

City, State, Zip

Telephone Number

( )

❒ **COBRA Enrollment -** I understand that I will be required to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied

Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date ______/_______/_______
Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

❒ Name Change ❒ Add new dependent ❒ Delete Dependent ❒ Address change listed above

Reason for change ______________________________ Effective date of change ______/______/
Month Day

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) First Middle Initial	Add/ Delete	Sex M F	Birthdate Month/Day/Year	Spouse's Social Security #	Marriage/Divorce Date Month/Day/Year
			____/____/____		____/____/____

Child Name Last (if different) First Middle Initial	Add/ Delete	Sex M F	Birthdate Month/Day/Year	Child's Social Security #

CCCOE Use Only

Coverage Level

Effective Date of Coverage

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to comply with the terms of the group contract.

Employee Signature ______________________________ **Date** ______________