The Business Council INSURANCE FUND

Group No.

Vision Enrollment Form

Social Security #	Employer:

Employee Name: (Last, First, Middle)	Date of Birth			Gender	Date of Hire		
	Month	Day	Year	Ĭ M Ĭ F	Month	Day	Year
Employee Mailing Address Zip Code							

If enrolling for coverage, please complete this section

I am enrolling for vison coverage as indicated:

Network Selection

ÿ VSP-Focus Plan ÿ EyeMed - ViewPointe Plan

Cover Tier Selection

ÿ Employee Only ÿ Employee/Child(ren) ÿ Employee/Spouse ÿ Family

Employee Statement - Enrolling for Coverage

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation; (b) I must be regularly working on a full-time basis at my employer's business establishment or at some other location to which my employer's business requires me to travel, and (c) I have completed any applicable waiting period

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required.

_____ Certified _____

Employee Signature Date Employer Representative Date

Dependent Information

Effective	Name of Eligible Dependents to be Covered	Date of Birth	Relationship