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| EYEMED_logoSM_primary_4c**EYEMED VISION PLAN**  **ENROLLMENT / CHANGE FORM**  District Logo_FINAL_cmyk | | | | | | | | | | | | | |
| **Group Number: 1033065**  **SubGroup ID: 1002** | | | | | | | **Effective Date:**  *(Return completed form to Payroll/Benefits Office)* | | | | | | |
| **Employer Name:** *Town of Simsbury – Simsbury Public Schools* | | | | | | | **Employer Address:** *933 Hopmeadow St, Simsbury, CT 06070* | | | | | | |
| ***Employee Information****: (Please Print – the following sections to be completed by the Employee)* | | | | | | | | | | | | | |
| **Type of Change:** | **Add** | | **Terminate** | | **Update** | | | | | | | | |
| ***Employee Last Name:*** | | | | ***Employee First Name:*** | | | | | | ***MI*** | ***Social Security Number*** | | |
| ***Employee Date of Birth***  *(MM-DD-YYYY)* | | ***Home Phone***  ***( )*** | | ***Union Affiliation:*** | | | | | ***Employee ID Number*** | | ***E-Mail Address*** | | |
| ***Street Address:*** | | | | ***City*** | | | | | ***State*** | | ***Zip Code*** | | |
| ***Employee and Dependent Information*:** *to be completed by Employee for* ***Individual, Two-Person or Family Coverage*** | | | | | | | | **Relationship**  *( Self, Spouse, Child, Step-Child)* | **Social Security Number**  *(Required)* | | | **Date of Birth**  *(MM-DD-YYYY)* | **Gender** |
| ***Last Name, First Name, MI*** *(Specify last name if different from yours)* | | | | | | | |
| *Employee* | | | | | | | |  |  | | |  |  |
| *Dependent 1* | | | | | | | |  |  | | |  |  |
| *Dependent 2* | | | | | | | |  |  | | |  |  |
| *Dependent 3* | | | | | | | |  |  | | |  |  |
| *Dependent 4* | | | | | | | |  |  | | |  |  |
| *Dependent 5* | | | | | | | |  |  | | |  |  |
| **Employee Signature / Date** | | | | | | | | **Employer Signature / Date** | | | | | |
| *Filename: EyeMed Enrollment Change Form 2021.docx* | | | | | |  | | | | | | | |