EYEMED VISION PLAN
ENROLLMENT / CHANGE FORM

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*** LAST NAME, FIRST NAME, MI *(Specify last name if different from yours)*	RELATIONSHIP *(Self, Spouse, Child, Step-Child)*	SOCIAL SECURITY NUMBER *(Required)*	DATE OF BIRTH *(MM-DD-YYYY)*	GENDER
EMPLOYEE				
DEPENDENT 1				
DEPENDENT 2				
DEPENDENT 3				
DEPENDENT 4				
DEPENDENT 5				

EMPLOYEE SIGNATURE / DATE	EMPLOYER SIGNATURE / DATE