Vision Care Plan
Humana Specialty Benefits

OFFICE USE ONLY:
Approval ______________
Effective Date ______________
Keyed ______________

Name ________________________________

Address ________________________________

City State Zip ________________________________

Date of Birth Employee ID# ____ Monthly ____ Biweekly ____ Retiree ____ COBRA

1. ________ **New Enrollment** Complete Sections 2, 3, 4, & 5 ________ **Add/Drop Dependent** Complete Sections 2, 3, 4, & 5 ________ **Decline/Cancel Plan** Complete Sections 2 & 6

2. **Reason for Section 1:** Please indicate **date** of event. ***Supporting Documentation will be required**

__/__/__ New Employee __/__/__ Birth*/Adoption* __/__/__ Spouse Begins/Ends Employment*

__/__/__ Marriage*/Divorce* __/__/__ Dependent becomes Ineligible __/__/__ Other* ______________

3. **Type of Coverage:**

________ **Employee Only** $6.68 ________ **Employee/Child(ren)** $12.70 ________ **Employee/Spouse** $13.34 ________ **Employee/Family** $19.94

4. **Dependent Information:** Please submit a *Dependent Certification* form for dependents aged 19-24. Employees are required to supply *supporting documentation* and/or *additional forms* for stepchildren and/or other dependents with different last names.

	Relationship	Dependent Name	Sex	Date of Birth	Social Security # {Required}
____ Add ____Drop	Spouse				
____ Add ____Drop	Child				
____ Add ____Drop	Child				
____ Add ____Drop	Child				

5. **Acceptance/Certification:**
I hereby request to be a participant under the North East I.S.D. Vision Plan. I understand that no benefit will become effective until the latest of the effective date of the plan or the date on which I satisfy the minimum service requirement as stated in the plan document. I hereby authorize my employer to make necessary payroll deductions from my paycheck, if any are required. I reserve the right to revoke the payroll deduction authorization annually on the plan anniversary date.

I hereby certify that the above information is correct and that a Dependent Certification form has been submitted for any dependent between the ages of 19-24. I also understand that I must notify Employee Benefits within 31 calendar days if any dependent ceases to be eligible.

________________________________ ______________ ________________________________
Employee Signature Date Campus/Department

6. **Declination or Cancellation of Benefit:**
After careful consideration, I have decided NOT to participate in or cancel the vision plan benefit and waive my rights to such benefit.

________________________________ ______________ ________________________________
Employee Signature Date Campus/Department

Original: Employee Benefits **Yellow Copy:** Employee