EyeMed VISION CARE® COLE MANAGED VISION

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Combined Insurance Company of America

Group Number	Client Name	Location Code N/A	Division Code N/A	Client Co Code N/A	Effective Date

SUBSCRIBER INFORMATION A: Add (enroll)

	Sex ☐ M ☐ F	UVI – Employee ID	Last Name (Subscriber)	First Name	M.I.	Date of Birth
	Mailing Address			**City/State/Zip**		**Home Phone ( )**

FAMILY INFORMATION (Only those eligible may be enrolled.)

☐Add	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐Add	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	
☐Add	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	
☐Add	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	
☐Add	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	

Subscriber Signature: _____ Date: _____

Instructions:

Plan name: Legal name of the plan.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: N/A.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as subscriber's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, address or phone.

Your Authorization:

I authorize payment for annual premium by payroll deduction:

$4.14 Per Subscriber only
$11.00 Per Subscriber + family

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date.
Revised for University of the Virgin Islands Participants on 05/2016.