INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME	GROUP NO.
Berkley School District	51984 0001 01 ☐ Administrators 51984 0001 99 ☐ Administrators Cobra 51984 0002 01 ☐ Non Affiliated 51984 0002 99 ☐ Non Affiliated Cobra 51984 0003 01 ☐ Secretaries 51984 0003 99 ☐ Secretaries Cobra 51984 0004 01 ☐ Adult Education 51984 0004 99 ☐ Adult Education Cobra 51984 0005 01 ☐ Teacher 51984 0005 99 ☐ Teacher Cobra

EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	GENDER	CONTRACT TYPE REQUESTED
— —	☐ Male ☐ Female	☐ Single (S) ☐ Employee + 1 (L) ☐ Family [Employee + 2 or more] (F)

EFFECTIVE DATE OF COVERAGE *OR* CHANGE	DATE OF HIRE

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY _____

	LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	SSN
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: X _____ DATE: _____

EMPLOYER SIGNATURE: X _____ DATE: _____

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.
1200 Route 46 West
Clifton, NJ 07013

Toll Free: (800) 672-7723