

## Vision Plan Enrollment Form State of Wisconsin Central Payroll Employees

**I. Check the Appropriate Boxes - - - Please Keep a Copy for Your Records - - -**

**A. COVERAGE DESIRED**  
 (all rates are monthly)

Employee Only            \$ 5.83

Employee + Spouse        \$ 11.34

Employee + Child(ren)    \$ 11.88

Employee + Family        \$ 17.82

**C. REASON FOR CHANGE IN STATUS**

Termination  
 Terminated employment on  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**If Terminated Select One:**

Decline COBRA offer.  
 Accept COBRA offer.

Marriage  
 Please enter date of marriage:  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent child married,  
 or reached age limit, or  
 is no longer a dependent.

Death date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Divorce date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name/Address Change

Adoption of child, date:  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

Retired, date paid through:  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**To continue coverage I understand I will be billed a single payment to cover premium for the balance of the year.**

**B. REASON FOR COVERAGE SELECTED:**

New Enrollment

Change of Status / Address

Cancel Coverage Effective 12/31/20\_\_\_\_  
(Enter Year)

**II. Employee Information (please print clearly):**

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Your Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_      Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**III. List All Eligible Family Members Below (if electing dependent coverage):**

	First Name	Last Name	Birth Date	Full Time Student?	Sex
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

*I agree to continue enrollment in the vision plan through December 31, 2008 and authorize you to deduct premiums from my payroll for vision care services in future periods. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.*

Your Signature \_\_\_\_\_ Date \_\_\_\_\_