



NORTHWESTERN
UNIVERSITY

Vision Plan Enrollment Form

(The Benefits Division will accept original forms only)

COBRA Participants

ACTION <input type="checkbox"/> New Enrollment <input type="checkbox"/> Dropping Dependents <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Other	MEMBERSHIP INFORMATION <input type="checkbox"/> Former Employee <input type="checkbox"/> Dependent/Spouse
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PERSONAL INFORMATION

NAME	Last _____ First _____	M.I.	EMPLOYEE ID _____	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
HOME ADDRESS	Street _____ Apt. _____	City _____	State _____	Zip _____
DATE OF BIRTH: ___/___/___	CHANGE EFFECTIVE DATE: ___/___/___	E-MAIL: _____	HOME PHONE: (____) _____ - _____	
MARITAL STATUS:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

VISION PLAN SELECTION

Please select the dental plan and type of coverage you wish to enroll in:

I ELECT TO: <input type="checkbox"/> enroll <input type="checkbox"/> waive <input type="checkbox"/> change VISION INSURANCE COVERAGE	<input type="checkbox"/> You only <input type="checkbox"/> You + spouse <input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse & child(ren)
Office Use Only: <input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider	Coverage Effective Date _____ Group and Section Number _____

OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health, Vision or Dental Insurance? Yes No If yes, please complete the following:

NAME OF INSURED:	EMPLOYER:	POLICY NUMBER:
INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:	

DEPENDENT INFORMATION

Please select whether you want your dependent(s) to be covered under your Vision Plan

Relationship	Date of Birth	Name (Last [if different], First MI)	Continue/Drop
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Partner	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop

AUTHORIZATION

(1) I elect coverage under the above-selected Vision Plan on behalf of myself and the above-listed dependents. (2) I certify that the above information is correct to the best of my knowledge and belief. (3) I hereby authorize any licensed dentist, hospital, clinic, government agency or other dental or medically-related facility, insurance company, organization or institution that has any records or knowledge of my dental or the dental of any member of my family to exchange such information with the above-selected dental care provider—including, without limitations, information relating to mental illness or use of drugs or alcohol. I understand that the information will be used for the purpose of review, investigation, or evaluation of coverage claims for vision insurance benefits provided to me and/or any of my dependents. (4) I agree to abide by the terms and conditions of the Plan Document and Certificates of Insurance.

This authorization is valid for the term of coverage of the contract under which this Vision Plan enrollment is effective. I am aware of my right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE _____

DATE _____