AB

Please complete the information below if your employer is offering Vision coverage with your Rocky Mountain Health Plans medical coverage.

Name of Employer Group:

Employee Information

Last Name:		First Name:	
Date of Birth: / /	Gender: ☐ M ☐ F	Social Security Number:	
Home Address:		City, State:	Zipcode:

☐ Yes, I am enrolling in Vision coverage, in addition to the medical plan.

☐ Yes, I am enrolling in Vision coverage and waiving enrollment in the medical plan.

Coverage requested for:

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

☐ I have listed dependents enrolling in the Vision Plan below.

Dependent Name	Gender	Birthdate	Relationship to Employee
		/ /	
		/ /	
		/ /	
		/ /	

☐ I am waiving vision coverage. I understand I am also waiving vision coverage for any eligible dependents and my next opportunity to enroll in the vision plan will be Open Enrollment.

I agree that enrollment, eligibility, coverage and benefits of the vision plan are subject to applicable policies and to all terms of the applicable coverage policy.

Signature: **Date:**

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