AB

Employee – Vision Enrollment/Change Form

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	Are you married? ☐ Yes ☐ No	Social Security Number:
Home Address:		City, State:	Zipcode:

Enrollment

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

☐ Yes, I am enrolling in Voluntary 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.

Spouse Name	Gender	Birthdate	Social Security Number

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

Waiver

☐ 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.

Add/Drop Information

I understand that if I drop vision coverage for myself, all covered family members will be disenrolled.

Reason for addition of dependent:
☐ Marriage ☐ Newborn or adopted child ☐ Employer group open enrollment ☐ Dependent lost other vision coverage

Add	Drop	Date	Last Name	First Name	MI	Sex M/F	Date of Birth mm/dd/yyyy	Relationship to Subscriber

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:**