INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME Morris Hills Regional District			GROUP NO. 4092 0001 01 ☐ Active 4092 0002 01 ☐ Retiree 4092 0003 99 ☐ Cobra
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER — —	GENDER ☐ Male ☐ Female	CONTRACT TYPE REQUESTED ☐ Single (S) ☐ Employee + Spouse (L) ☐ Employee + Child(ren) (E) ☐ Family [Employee, Spouse, Child(ren)] (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	STUDENT (Y/N)
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