

**GROUP NUMBER: 05890**

**NOTE TO GROUP ADMINISTRATORS:**  
 Submit this form to Medical Eye Services for initial group enrollment only. All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.

**VISION PLAN ENROLLMENT/CHANGE REQUEST**

								Employee Effective Date:	
<b>EMPLOYEE INFORMATION</b>									
Current Last Name					First Name			MI	
Address					Employee ID Number/Social Security Number				
City			State		Zip Code		Date of Hire		
Group Name					MES Group Number				
<b>PLEASE ENROLL/CHANGE MY PLAN AS INDICATED</b>									
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Add dependent(s) <input type="checkbox"/> Delete dependent(s)            If adding spouse, give marriage date:									
Eligible dependents are your spouse and unmarried children within the ages stated in your evidence of coverage. Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the MES Vision evidence of coverage.									
<input type="checkbox"/> Change my name as shown. My former name is:									
<b>LIST BELOW ALL DEPENDENTS</b>									
Effective Date	Change	Relationship	Sex	First Name	MI	Last Name	Date of Birth (mm/dd/yyyy)	Full-time Student?	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Del							<input type="checkbox"/> Yes <input type="checkbox"/> No	

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER**