



ASSOCIATION: LODI ASSOCIATION OF REALTORS

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 Service Form and submitted with your monthly premiums.

VISION PLAN ENROLLMENT/CHANGE REQUEST

EMPLOYEE INFORMATION							Employee Effective Date:	
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				
PLEASE ENROLL/CHANGE MY PLAN AS INDICATED								
<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:								
LIST BELOW ALL DEPENDENTS								
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