INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
Please Print or Type

(GROUP)	(EMPLOYER)	GROUP NO. 43274	
Labor Association of WI, Inc.		If applicable, Local # _____	
EMPLOYEE LAST NAME	FIRST	M.I.	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER – –	GENDER ❑ Male ❑ Female	TELEPHONE:	
EFFECTIVE DATE OF COVERAGE OR CHANGE:		CONTRACT TYPE REQUESTED ❑ Single (S) ❑ Family (F)	

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 NEW CARD ❑ CHANGE OF 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: _____