INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME	GROUP NO.
Moravian College	☐ **51093000001 -- Basic** ☐ 51093000099 – Basic COBRA ☐ **51093000002 -- Enhanced** ☐ 51093000098 – Enhanced COBRA

EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	GENDER	CONTRACT TYPE REQUESTED
___ ___	☐ **Male** ☐ **Female**	☐ **Single (S)** ☐ **Employee + 1 (L)** ☐ **Family [Employee + 2 or more] (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.
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Clifton, NJ 07013

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