

**Vision Plan Application  
UW System Employee**



**Section I**

Employee/Applicant Information			
Name (Last, First, MI)			Birth Date (mm/dd/yyyy)
Address	City	State	ZIP

**Section II**

**Reason for Submitting Application (Check the appropriate reason)**

Initial Enrollment (Complete all Sections)

Change of Name or Address (Complete Sections I and V only)

Adding Dependent(s) [Complete all Sections, listing in Section IV the dependent(s) being added]  
 Event Date: \_\_\_\_\_ (mm/dd/yyyy)  
 Marriage     Domestic Partnership     Birth     Adoption  
 Other: \_\_\_\_\_

Deleting Dependent(s)  
 Event Date: \_\_\_\_\_ (mm/dd/yyyy)  
 Dependent(s) to be deleted: \_\_\_\_\_  
 Death     Domestic Partnership Termination     Dependent Married  
 Divorce     Dependent reached age limit     Other: \_\_\_\_\_

Canceling Coverage\* (Complete Sections I and V only)  
 \*Note: Cancellation is effective at the end of the year in which the request is submitted

Termination of Employment \_\_\_\_\_ (mm/dd/yyyy)

Other: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

**Section III**

Coverage Desired	Monthly Rates
<input type="checkbox"/> Employee/Applicant Only	\$5.24
<input type="checkbox"/> Employee/Applicant + Spouse/Domestic Partner	\$10.49
<input type="checkbox"/> Employee/Applicant + Child(ren)	\$11.23
<input type="checkbox"/> Employee/Applicant + Family	\$17.93

**Section IV**

Complete the following information ONLY for individuals covered by the policy

Last Name	First Name	Birth Date (mm/dd/yyyy)	Gender	Relationship (Spouse, Dom. Partner, Child, Student, Disabled Dependent)	Tax Dependent
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N

**Section V**

**Date, Sign and Submit this form to your Benefits/Payroll/Personnel Office**

By signing below, I agree that all information is true. I understand that I am enrolling in a voluntary plan and that VSP will automatically deduct the entire monthly vision premiums from my paycheck. I agree to continue enrollment in the vision plan through December 31 of the current calendar year. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.

<b>Date (mm/dd/yyyy)</b>	<b>Signature</b>	<b>Work Phone</b>
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**For Office Use Only**

PERSON ID	Hire Date	Campus/Location	Add/Change Effective Date	Date Received	Received By	Deduction Code	Group #
						411	30015848 / 2001 / 2001