Vision Plan Application
UW Hospitals & Clinics Employee

Section I

Employee/Applicant Information				
Name (Last, First, MI)	Social Security Number	Date of Hire	Birth Date (MM/DD/YY)	
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: ______________________
  - ☐ Marriage ☐ Domestic Partnership ☐ Birth ☐ Adoption
  - ☐ Other:_______________
- ☐ Deleting Dependent(s)
  - Event Date: ______________________
  - Dependent(s) to be deleted: ____
  - ☐ Death ☐ Domestic Partnership Termination ☐ Dependent Married
  - ☐ Divorce ☐ Dependent reached age limit ☐ Other:_________________
- ☐ Other ____

Section III

Coverage Desired	Monthly Rates
☐ Employee/Applicant Only	$5.24
☐ Employee/Applicant + Spouse/Domestic Partner	$10.49
☐ Employee/Applicant + Child(ren)	$11.23
☐ 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/yy)	Gender	Relationship (Spouse, Dom. Ptr., Child, Step-child, Disabled Dependent)	Tax Dependent[1]
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N

[1] Tax Dependent: Indicate Yes or No if your domestic partner and/or dependent child is considered your "tax dependent" under federal law. You do not need to complete this box for your spouse. Note that your vision insurance premium will be taken from your paycheck post-tax if you cover dependents that are not your "tax dependents."

Section V

Date, Sign and Submit this form to your Human Resources 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.

Date (mm/dd/yy)	Signature

For Office Use Only

Member ID (SSN)	Hire Date	Location	Effective Date	Date Received	PS Entry by	Group #
		UW Hospitals and Clinics				30015848 / 3001 / 3001