OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

VISION SERVICE PLAN
ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1.

Employee Name: _____ UIN: _____
Print Last name, first name, middle initial

SECTION 2.

_____**Waive** Employee coverage _____**Waive** Dependent Coverage

SECTION 3. ___New ___Open Enrollment ____ADD ____Cancel

_____Employee Only _____Employee plus children

_____Employee plus one dependent _____Employee plus family

SECTION 4. Please list all persons to be covered by this application.

_____ _____ / _____ / _____
1. Self (print: Last, First) Date of Birth

_____ _____ / _____ / _____
2. Dependent Name (print: Last, First) Date of Birth

_____ _____ / _____ / _____
3. Dependent Name (print: Last, First) Date of Birth

_____ _____ / _____ / _____
4. Dependent Name (print: Last, First) Date of Birth

SECTION 5. Authorization -

_____ _____
Employee Signature Date

Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: _____