



CITY OF VENICE

Group Vision Insurance Enrollment/Change Form

Section 1: Personal Information					
Employee Name (Last, First, MI)	Social Security No.	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Home Street Address	City	State	Zip Code	Telephone No.	
Section 2: New Enrollment					
<input type="checkbox"/> DECLINE	Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Family <i>(Must complete Section 4)</i>			Effective Date:	
Section 3: Change					
<input type="checkbox"/> CHANGE COVERAGE to <input type="checkbox"/> Employee Only <input type="checkbox"/> Family <i>(Must complete Section 4)</i>				Effective Date:	
<input type="checkbox"/> DROP ALL COVERAGE	<input type="checkbox"/> DROP DEPENDENT <i>Complete Section 4</i>	<input type="checkbox"/> ADD DEPENDENT <i>Complete Section 4</i>			
Section 4: Dependent Information (Attach additional sheet of paper, if necessary. Sign and date it.)					
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship SPOUSE
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship CHILD
Section 5: Acceptance/Declination of Coverage					
<input type="checkbox"/> I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.			<input type="checkbox"/> I do not wish to apply for any coverage. I understand that if I decide to apply at a later time, coverage may not be available until the next open enrollment.		
Section 8: Signature					
Employee Signature				Date	