Vision Insurance
ENROLLMENT FORM

Employee Name: _____ **Social Security** _____

(Last, First, Middle Initial)

Sex _____ **Marital Status** _____

Home Address _____ **Date of Birth** _____

_____ **Date of Hire** _____

City, State Zip _____ **Division/Location** _____

****

Dependent Information: **Full Name** **Social Security Number** **Date of Birth** **Sex**

Spouse: _____ _____ _____ _____

Children: _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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Monthly Deductions:

Employee Only	**$8.65**
Employee + One	**$13.85**
Employee + Children	**$14.14**
Employee + Family	**$22.79**

Option Choice _____ **Employee Cost $**_____

Applicant Signature: _____ **Date:** _____/_____/____ ☐ **Decline Vision Insurance**

To Be Completed By Employer

Employer Name: Bay County Employees Group: _____ Division: _____

Information on this application regarding eligibility requirements for employees & dependents has been verified by the employer, Bay County Employees.

_____ _____

Employer Signature Date

Effective Date: _____/_____/_____