Returned completed form to Human Resources
Upload in MedHub

NEW HIRE EIT RESIDENT

Vision Plan Application
UW Hospitals & Clinics Employee

Employee ID: _____

Section I

Employee/Applicant Information			
Name (Last, First, MI)			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 a Dependent [Complete all Sections, listing in Section IV the dependent(s) being added]~~
  - ☐ ~~Marriage _____ (date)~~
  - ☐ ~~Birth _____ (date)~~ ☐ ~~Adoption _____ (date)~~
  - ☐ ~~Other _____ (date)~~
- ☐ ~~Deleting Dependent(s)~~
  - ☐ ~~Death _____ (date)~~
  - ☐ ~~Divorce _____ (date)~~ ☐ ~~Dependent reached age limit _____ (date)~~
  - ☐ ~~Other _____ (date)~~
- ☐ ~~Canceling Coverage (Complete Sections I and V only)~~
  ~~*Note: Cancellation is effective at the end of the year in which the cancellation form is submitted~~
- ☐ ~~Termination _____ (date)~~
- ☐ ~~Other _____ _____ (date)~~

Section III

Coverage Desired	Monthly Rates
☐ Employee/Applicant Only	$6.38
☐ Employee/Applicant + Spouse	$12.76
☐ Employee/Applicant + Child(ren)	$14.38
☐ Employee/Applicant + Family	$22.98

Section IV

Complete the following information ONLY for individuals covered by the policy

Last Name	First Name	Birth Date (mm/dd/yy)	Gender	Relationship	Tax Dependent
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ 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.

Date (mm/dd/yy)	Signature

For Office Use Only

Member ID	Hire Date	Location	Coverage/Change Effective Date	Date Received	Received By	Group #
		UW Hospitals & Clinics				30015848 3001 / 3001