



ENROLLMENT FORM GROUP VISION PLAN

EMPLOYEE INFORMATION					
GROUP NAME			GROUP POLICY NUMBER		MES GROUP NUMBER
EMPLOYEE EFFECTIVE DATE	FIRST NAME	MI	LAST NAME		
ADDRESS			SOCIAL SECURITY NUMBER		DATE OF BIRTH
CITY			STATE	ZIP CODE	DATE OF HIRE

LIST BELOW ALL ENROLLING DEPENDENTS

Eligible dependents are your spouse and unmarried children within the ages stated in your policy. Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Policy.

RELATIONSHIP	SEX	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	FULL TIME STUDENT
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO

Signature _____

Date _____

PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER

NOTE TO GROUP ADMINISTRATORS

Submit this form to Blue Shield Life for initial group enrollment only. All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.

