Vision care for life

`Enrollment Application Form

Name of Group (employer): **University of Montevallo**

Employee Last Name, First Name, MI: _____

Social Security Number: _____

Date of birth (month/date/year): _____

Gender: ☐ **Male** ☐ **Female**

Effective Date of Coverage: _____

Type of Coverage Selected: ☐ **Employee Only**

☐ **Family**

☐ **Waive Coverage**

***Dependent Relationship: S=Spouse, C=Child, H=Handicapped Child,**

Dependent Last Name	Dependent First Name	Gender	*Dependent Relationship ☐S ☐C ☐H	Date of Birth MM/DD/YYYY
			☐S ☐C ☐H	
			☐S ☐C ☐H	
			☐S ☐C ☐H	
			☐S ☐C ☐H	
			☐S ☐C ☐H	
			☐S ☐C ☐H	
			☐S ☐C ☐H	

Employee Signature: _____ **Date:** _____ **M#:** _____

If you have any questions please call HR at (205) 665-6055