



P.O. Box 7725, San Francisco, California 94120
 1-888-800-2742

EMPLOYEE GROUP VISION PLAN ENROLLMENT FORM

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	SEX
CITY			STATE	ZIP CODE	DATE OF HIRE	

LIST BELOW ALL ENROLLING DEPENDENTS

Eligible dependents are your spouse/domestic partner and your or your spouse's/domestic partner's unmarried children within the ages stated in your policy. Coverage granted to individuals listed heron 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