AAAS employee benefit fund

**AAAS Employee Benefit Fund**
**11245 Chantilly Parkway Court**
**Pike Road, AL 36064**
**kay@aaas.us | f 334.834.1818**

BlueCross BlueShield of Alabama
VSP Vision care for life

# VISION - Application for Enrollment/Changes

| GROUP |
|---|
| 77220 |

| Employer Company Name | | | | Employer Phone Number |
|---|---|---|---|---|
| Employee Name (Last) | (First) | (Initial) | | Employee Phone Number |
| Street Address | City | State | Zip | Employee Date of Birth |

| CHECK ONE: | CHECK ONE: | Employee's Social Security Number | Date of Hire |
|---|---|---|---|
| ❍ Male<br>❍ Female | ❍ Single ❍ Divorced<br>❍ Married ❍ Widowed | | |

| LIST ALL ELIGIBLE DEPENDENTS TO ENROLL<br>LAST NAME FIRST NAME INITIAL | SOCIAL SECURITY NUMBER | RELATIONSHIP<br>S=spouse, C=child, H=handicapped child, T=student | DATE OF BIRTH<br>M | D | Y |
|---|---|---|---|---|---|
| 1. | | ❍S ❍C ❍H ❍T | | | |
| 2. | | ❍S ❍C ❍H ❍T | | | |
| 3. | | ❍S ❍C ❍H ❍T | | | |
| 4. | | ❍S ❍C ❍H ❍T | | | |
| 5. | | ❍S ❍C ❍H ❍T | | | |

| Vision Coverage Types<br>(select one) |
|---|
| ❍ **Employee** |
| ❍ **Employee + Spouse** |
| ❍ **Employee + Children** |
| ❍ **Employee + Family** |

I wish to enroll in the coverage indicated above as offered through my employer. I understand that there is a minimum one-year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature of Employer _____ Date: _____

Signature of Employee _____ Date: _____

Requested Start Date: _____

| AAASEBF Use Only | | | |
|---|---|---|---|
| **Effective Date** | **Division #**<br>V00 | **Contract #** | **B** / **A** |