LOYOLA UNIVERSITY NEW ORLEANS

VISION SERVICE PLAN – MEMBERSHIP ENROLLMENT FORM

Group # 2229063

EMPLOYEE: _____ ___ ___/___/___
LAST **FIRST** **MI** **SS#**

HOME ADDRESS: _____ **EMAIL:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HIRE DATE: ___/___/___ **SEX: F M (circle one)** **BIRTH DATE:** ___/___/___

Coverage - Check one:			
	Coverage Level		**Coverage Level**
☐	Employee Only	☐	Employee + Child
☐	Employee + Spouse	☐	Family
☐	Cancel Coverage	☐	Waive Coverage

Family Members to be covered:

Name	Relationship	Sex	DOB
Name	Relationship	Sex	DOB
Name	Relationship	Sex	DOB
Name	Relationship	Sex	DOB
Name	Relationship	Sex	DOB
Name	Relationship	Sex	DOB

Signature_____**Date**_____