LOYOLA UNIVERSITY NEW ORLEANS

VISION SERVICE PLAN – MEMBERSHIP ENROLLMENT FORM

Group # 2229063 Effective Date: _____

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_____

Rev. 11/21/2008