

VISION ENROLLMENT/CHANGE FORM

<p>Plan Selected</p> <input type="checkbox"/> Eye Med Access B <input type="checkbox"/> VSP I <input type="checkbox"/> VSP II <input type="checkbox"/> Indemnity Vision <p>Check One</p>
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IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION		FOR PIBT USE ONLY
Company Name	Phone ()	
Address		GROUP #
New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Other <input type="checkbox"/> Changes (Check appropriate boxes) <input type="checkbox"/> Add dependent(s) - List information in Section 3 <input type="checkbox"/> Address change - Complete Section 2 <input type="checkbox"/> Name change - Complete Sections 2 and 3		Additions, Terminations or Changes of Coverage: Report all additions, terminations or changes of group coverage to Printing Industries Benefit Trust no later than the 20th day of the month in which it is effective. COVERAGE EFFECTIVE DATE PIBT ACCOUNT NO.

SECTION 2 EMPLOYEE INFORMATION			
Last Name	First Name	M.I.	<input type="checkbox"/> Single <input type="checkbox"/> Married Date of Marriage _____ <input type="checkbox"/> Domestic Partner Registration Date _____
Social Security Number	Full Time Hire Date	Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Job Title
Residence Mailing Address (Number, Street, Apartment)		City	State Zip
Home Telephone ()		Mobile Phone Number ()	

NOTE: Any dependent child age 19 or over will not be added until Section 4 on the back of this form is completed and approved.

SECTION 3 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION											
Name	Last	First	M.I.	Birthdate	Sex	Name	Last	First	M.I.	Birthdate	Sex
Employee				MM/DD/YYYY	F <input type="checkbox"/> M <input type="checkbox"/>	Second dependent*				MM/DD/YYYY	F <input type="checkbox"/> M <input type="checkbox"/>
SS #	—	—		Relationship		SS #	—	—		Relationship	
Spouse				Date of Marriage	F <input type="checkbox"/> M <input type="checkbox"/>	Third dependent*				MM/DD/YYYY	F <input type="checkbox"/> M <input type="checkbox"/>
SS #	—	—		Relationship <input type="checkbox"/>		SS #	—	—		Relationship <input type="checkbox"/>	
First dependent*				Birthdate	F <input type="checkbox"/> M <input type="checkbox"/>	Fourth dependent*				MM/DD/YYYY	F <input type="checkbox"/> M <input type="checkbox"/>
SS #	—	—		Relationship <input type="checkbox"/>		SS #	—	—		Relationship <input type="checkbox"/>	

SECTION 4 FULL TIME STUDENT VERIFICATION

Any dependent age 19 or over cannot be added unless they are a full-time student. Requirements for dependent student coverage: Full-time student in an accredited institute, dependent upon employee for support, unmarried, under 25 years of age.

Dependant's Name	Birthdate	School Year
School Name	Student I.D. #	Current # of Units
School Address	City	State Zip
Dependant's Name	Birthdate	School Year
School Name	Student I.D. #	Current # of Units
School Address	City	State Zip

SIGNATURE	DATE
I accept the coverage/insurance benefits provided by this group vision plan and authorize the processing of my enrollment in the vision coverages as indicated on this form. I authorize the deduction from my earnings of the required contributions, if any, toward the cost of the coverage. I authorize payment of vision benefits to the provider of vision care.	

PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize any Provider, Insurance Company, Employer or Organization to release any information, on me or my dependents, regarding the medical, vision, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan.

I authorize that payment be made under Part B of Medicare to participating provider for medical and other services furnished me for which it pays or has paid, if applicable.

I understand that any controversy between any Member and Printing Industries Benefit Trust (including its agents, staff physicians and employees) and its providers involving a claim in tort, contract or otherwise, is subject to binding arbitration. (Applicable only to CA residents.)

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform Printing Industries Benefit Trust and will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of dependents collect benefits or damages from any other party who has primary responsibility for services provided by the plan, I will immediately reimburse the plan to the extent of services provided, to the extent permitted by state law.

EMPLOYEE

- Do not complete employer section.
- Complete the EMPLOYEE section, making sure that your Social Security Number is correct when you enroll and whenever you make a change.
- Complete the entire DEPENDENT section if you want your dependents (spouse or children) to be covered under your plan.
- Always sign and date the form.
- Return the completed form to your employer when you are done.

EMPLOYER

- Complete employer section.
- Check that the employee has completed the EMPLOYEE section.
- Be sure that the form is signed and dated.

LATE ENROLLMENT

- Late enrollment for other than specific instances will not be approved onto the plan until open enrollment. Please contact Printing Industries Benefit Trust for further information.