Vision Insurance Enrollment Form

WEA Insurance Corporation
P.O. Box 259537, Madison, WI 53725-9537
800.279.4000 · WEATrust.org

Please complete every section and every field on this form. Applications not completed in full cannot be processed.

Section 1–Employee Information

Employee Legal Name (Last, First, Middle Initial)

Street Address (or P.O. Box) **City** **State** **Zip**

Date of Birth (MM/DD/YYYY) **Telephone Number**

Social Security Number **Subscriber ID Number** (not applicable for first time enrollment)

Gender
☐ **Male** ☐ **Female**

Marital Status
☐ **Single** ☐ **Married** ☐ **Domestic Partnership**

Are you:
☐ Totally disabled? ☐ On sick leave? ☐ On medical leave? ☐ Retired? ☐ On COBRA?
If YES, please provide start date: ___/___/_____

Section 2–Employment Information

Employer Name

WEA Trust Group Number **First Day of Employment** (MM/DD/YYYY) **Annual Salary** **Average Hours Worked/Week**

Occupation

Section 3–Reason for Enrollment

Choose one of the reasons for your enrollment below:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Group Annual Open Enrollment
☐ Birth, adoption/placement for adoption
☐ Marriage, adding spouse and/or dependents
☐ Change in work hours
Indicate the number of hours per week you *were* working:
_____ hours
☐ Divorce
☐ Change of Occupation
Previous Occupation: _____
☐ Other: _____

Date the event indicated above occurred (MM/DD/YYYY)

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Employee Social Security Number or Subscriber ID Number: _____

Section 4–Type of Insurance Coverage *(to determine which plan you are eligible for, please check with your employer)*

☐ **Vision**
Type of Coverage: ☐ Single ☐ Family

Section 5–Waiver of Coverage

Does your employer pay the full premium for your vision coverage? ☐ Yes ☐ No

Important Note: If yes, you must enroll in the group vision plan. You may not waive coverage.

If No, and you choose not to elect coverage for you, your spouse/domestic partner, and/or your dependent children, please complete the following:

☐ Myself ☐ My spouse ☐ My domestic partner ☐ My dependent child(ren)

I understand that if I do not apply for vision coverage when initially eligible, I and my dependent may have to wait until my employer's annual open enrollment period to enroll later.

Signature:_____ Date:_____

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Employee Social Security Number or Subscriber ID Number: ______________________________

Section 6–Dependent Information *(Please complete in full if you are applying for dependent life coverage)*

______________________________ ____/____/______ ______/______/______

Last Name **First Name** **Middle Initial** **Date of Birth (mm/dd/yyyy)** **Social Security Number**

Relationship of Dependent: ☐Spouse ☐Domestic Partner ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________________

Gender: ☐ Male ☐ Female **Is this dependent disabled**: ☐ Yes ☐ No

______________________________ ____/____/______ ______/______/______

Last Name **First Name** **Middle Initial** **Date of Birth (mm/dd/yyyy)** **Social Security Number**

Relationship of Dependent: ☐Spouse ☐Domestic Partner ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________________

Gender: ☐ Male ☐ Female **Is this dependent disabled**: ☐ Yes ☐ No

______________________________ ____/____/______ ______/______/______

Last Name **First Name** **Middle Initial** **Date of Birth (mm/dd/yyyy)** **Social Security Number**

Relationship of Dependent: ☐Spouse ☐Domestic Partner ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________________

Gender: ☐ Male ☐ Female **Is this dependent disabled**: ☐ Yes ☐ No

______________________________ ____/____/______ ______/______/______

Last Name **First Name** **Middle Initial** **Date of Birth (mm/dd/yyyy)** **Social Security Number**

Relationship of Dependent: ☐Spouse ☐Domestic Partner ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________________

Gender: ☐ Male ☐ Female **Is this dependent disabled**: ☐ Yes ☐ No

For each additional dependent - attach a separate piece of paper including the information above

Section 7–Signature and Authorization Required to Process Form (Must sign and date if enrolling)

To the best of my knowledge, I agree that the information I have provided is true and accurate. If I elected vision coverage for myself and my dependents, I understand that I and my dependents may not voluntarily terminate vision coverage before my employer's annual open enrollment period that occurs after I and my dependents have been enrolled for a period of at elast 12 consecutive months. I hereby authorize my employer to make all necessary deductions

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Signature **Date (MM/DD/YYYY)**