Hopkins County Board of Education

APPLICATION FOR COBRA VISION INSURANCE

(Please Print or Type)

EMPLOYEE'S NAME:_____
LAST FIRST MIDDLE INITIAL

ADDRESS:_____

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER: ___ ___ ___-___ ___-___ ___ ___ ___

MALE_____ FEMALE_____ DATE OF BIRTH:__ __-__ __-__ __

EFFECTIVE DATE:__ __-__ __-__ __

COVERAGE STATUS DESIRED: __EMPLOYEE ONLY

__EMPLOYEE & ALL DEPENDENTS

THE MONTHLY PREMIUM IS $7.18 FOR EMPLOYEE ONLY, AND $ 23.80 FOR EMPLOYEE AND ALL DEPENDENTS.

IF DEPENDENT COVERAGE IS CHOSEN, PLEASE LIST ALL ELIGIBLE DEPENDENTS:

	LAST NAME	FIRST NAME	MIDDLE INIT	BIRTH DATE
				MO | DAY | YR
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

(ADD OTHERS IF NECESSARY)

I have elected to take the Vision Cobra Insurance and all premium(s) will be paid to date.

SIGNATURE_____ DATE_____

FOR CENTRAL OFFICE USE ONLY

EFFECTIVE DATE:_____ DATE SHIPPED TO VSP:_____

BENEFITS/FINANCE PERSONNEL:_____