OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

VISION SERVICE PLAN
ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1.

Employee Name:______________________________ UIN:______________
Print Last name, first name, middle initial

_____Employee Only _____Employee plus children
be covered by this application.

________________________________ ________ / ________ / ________
1. Self(print: Last, First) Date of Birth

________________________________ ________ / ________ / ________
2. Dependent Name (print: Last, First) Date of Birth

________________________________ ________ / ________ / ________
3. Dependent Name (print: Last, First) Date of Birth

________________________________ ________ / ________ / ________
4. Dependent Name (print: Last, First) Date ofBirth

SECTION 5. Authorization -

__________________________ __________________
Employee Signature Date

Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: ______________________

P.O. Box 6369 4111 Monarch Way, Suite 202 Norfolk, VA 23508757-683-4293