SUPERIOR VISION

# Enrollment Form

**Employer:** WAUKESHA COUNTY **Group Number:** _____

**Date of Hire:** _____ **Effective Date:** _____

## Employee Information

Employee Name: _____
First M.I. Last

Employee Soc. Sec. # _____-_____-_____ Sex: ☐ M ☐ F

Employee Birthdate: _____/_____/_____ Home Phone: (_____)_____

Home Address: _____

City: _____ State: _____ Zip:_____

**COVERAGE**: ☐ SINGLE ☐ E+1 ☐ FAMILY

**PLAN**: ☐ FULL SERVICE (exam & materials) ☐ WAIVE

## Covered Dependents

| Name | Birthdate | Relationship | Soc. Sec. # |
|---|---|---|---|
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |

EMPLOYEE SIGNATURE: _____ DATE:_____

In order for us to properly enter you into our computers, we need ALL information on this form filled out at time of enrollment. Thank you.

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