



OLD DOMINION UNIVERSITY

Research Foundation

VISION SERVICE PLAN

ENROLLMENT- CHANGE FORM – Vision Care

Name of Employer: Old Dominion University Research Foundation

Employee Name: _____ UIN: _____

Print Last name, first name, middle initial

Employee Only Coverage

Waive Employee coverage

CHANGE coverage

Waive Dependent Coverage

DEPENDENT coverage selected:

CHANGE coverage selected:

Employee plus one dependent

ADD coverage **DROP** coverage

Employee plus children

Employee

Employee plus family

Dependent Spouse

Dependent Child(ren)

_____/_____/_____
1. Spouse Dependent Name (print: Last, First) Dependent Date of Birth

_____/_____/_____
2. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____/_____/_____
3. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____/_____/_____
4. Child Dependent Name (print: Last, First) Dependent Date of Birth

Employee Signature

Date

Effective Date

Web Updated