

**The Association Insurance Benefit Trust
Vision Program by Superior Vision Services**

Administered by Beneficial Administration LLC
2505 McCabe Way, Irvine, CA 92614
Phone: 1-800-854-7417 • Fax: (949) 724-1603



Employee Change Form

Employer Group Name: _____

Employee First Name: _____ M.I.: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____

Change in Employee Information

CHANGE OF ADDRESS OR NAME:

New mailing address: _____

New city/state/zipcode: _____

New telephone: _____ New Email: _____

New name: _____ Reason: _____

Change in Plan Selected or Coverage Elected

CHANGE OF PLAN:

Old Vision Plan Selected: High Mid Low Materials Only

New Vision Plan Selected: High Mid Low Materials Only

CHANGE OF COVERAGE:

Old Coverage Elected: Single Spouse/DP Child(ren) Family

New Coverage Elected: Single Spouse/DP Child(ren) Family

Delete/Add Dependent(s)

ACTION: **NAME:** **SOC.SEC. NO. :** **DATE OF BIRTH:** **EFFECTIVE DATE:**

Delete/ Add _____ | ____/____/____ | _____

Delete/ Add _____ | ____/____/____ | _____

Delete/ Add _____ | ____/____/____ | _____

Delete/ Add _____ | ____/____/____ | _____

I understand that such coverage will not go into effect until approved by my employer and accepted by the administrator of the plan and I hereby authorize my employer to make any necessary deductions from my paycheck to collect my portion of any cost of coverage for which I may be responsible. I understand that my enrollment in the vision plan, while voluntary, requires that **I remain enrolled through the next plan enrollment period which may be as long as twelve months from the date of my signature below.**

Employee Signature: _____

Dated: _____