MEDICAL EYE SERVICES
VISION ADMINISTRATORS

NOTE TO GROUP ADMINISTRATORS

Submit this form to Medical Eye Services for initial group enrollment only. All additions or changes to the original group enrollment should be reported on the Eligibility Control Form and submitted with your monthly premiums.

VISION PLAN ENROLLMENT/CHANGE REQUEST

Employee Effective Date:

EMPLOYEE INFORMATION

Current Last Name		First Name	MI
Address		Employee ID Number/Social Security Number	
City	State	Zip Code	Date of Hire
Group Name		MES Group Number	

PLEASE ENROLL/CHANGE MY PLAN AS INDICATED

☐ New Enrollee ☐ Add dependent(s) ☐ Delete dependent(s) | If adding spouse, give marriage date:

Eligible dependents are your spouse and unmarried children within the ages stated in your evidence of coverage.
Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the MESVision evidence of coverage.

☐ Change my name as shown. My former name is:

LIST BELOW ALL DEPENDENTS

Effective Date	Change	Relationship	Sex	First Name	MI	Last Name	Date of Birth (mm/dd/yyyy)	Full-time Student?
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No
	◉ Enroll ○ Add ○ Del							◉ Yes ○ No
	◉ Enroll ○ Add ○ Del							○ Yes ◉ No

SIGNATURE: ____ DATE: ____________________

PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER

