

# HOW TO ENROLL IN VISION?

\*Complete section one if you  
are enrolling

\*Mark "new enrollment"

\*Sign & date section four.



## INDIVIDUAL ENROLLMENT/CHANGE FORM For VISION COVERAGE (Please Print or Type)

EMPLOYER (GROUP) NAME Meridian Industries, Inc.				GROUP NO. 8673 0000 12 <input type="checkbox"/> Meridian Corporate 8673 0001 08 <input type="checkbox"/> Kleen Test Products 8673 0001 09 <input type="checkbox"/> Kleen Test Products- Loc 9 8673 0002 01 <input type="checkbox"/> Aurora Non Union 8673 0002 02 <input type="checkbox"/> Aurora Union 8673 0003 13 <input type="checkbox"/> MSYG Valdese 8673 0004 30 <input type="checkbox"/> MSYG Rantlo 8673 0005 10 <input type="checkbox"/> Majilite Corporation 8673 0005 11 <input type="checkbox"/> Majilite Manufacturing	
Monthly Premiums	Employee Only \$3.88	Employee + Spouse \$7.77	Employee + Child(ren) \$12.42	Employee + Spouse + Child(ren) \$14.36	
EMPLOYEE LAST NAME		FIRST	MI	DATE OF BIRTH	
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Employee + Spouse (L) <input type="checkbox"/> Employee + Child(ren) (E) <input type="checkbox"/> Family [Employee, Spouse, Child(ren)] (F)		
EFFECTIVE DATE OF COVERAGE OR CHANGE			DATE OF HIRE		

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY \_\_\_\_\_

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE:

EMPLOYEE SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.  
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Clifton, NJ 07013

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\*Mark which plan type you  
would like

\*If you are adding dependents,  
insert their information  
in section three