# Mendon Community Schools
# Vision Benefit Plan
## Group Enrollment Application

Preferred
BENEFIT ADMINISTRATORS
INCORPORATED
PO BOX 916188, LONGWOOD, FL 32791-6188

**Please Print Clearly**

**Employer:** Mendon Community Schools **Group: 460**

**Employee Name:** _____ **Member ID #:** _____
(Will be assigned by Claims Administrator)

**Address:** _____
**Street Address** **City** **State** **Zip Code** **Telephone #**

**Date of Full-time Employment:** _____ **Date of Birth:** _____ **Gender:** ☐ **M** / ☐ **F**

**Occupation:** _____ **Social Security Number:** _____
(Will be used for identification purposes and Federal reporting only)

### INDICATE DESIRED COVERAGE BELOW:

**Vision Plan Coverage:**

- ☐ **Employee Only**
- ☐ **Employee + Spouse**
- ☐ **Employee + Child(ren)**
- ☐ **Family**
- ☐ **Waive Coverage - Reason:** _____

| **Complete Dependent Information ONLY if you are electing Dependent Vision Coverage** | | | | |
|---|---|---|---|---|
| Full Name of Dependent | Date of Birth | Gender | Relationship to Employee | Social Security # |
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**Unless otherwise indicated, I hereby request the Group Vision Benefits to which I am or may be entitled and authorize required deductions towards the cost, if applicable. I further authorize any physician, medical practitioner, hospital, medical facility, insurance company, government-sponsored health plan or employer having medical information about me or my covered dependents which relates to the diagnosis, treatment and prognosis of any illness or injury to release this information to Preferred Benefit Administrators, Inc. This authorization shall remain in effect as long as I remain covered by the plan.**

_____
**Employee Signature** **Date**

**FOR ADMINISTRATIVE USE ONLY**
**Effective Date:** _____ **Entered in Eldo:** _____