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
☐ **CHANGE** coverage
☐ **Waive** Employee coverage
☐ Waive Dependent Coverage

DEPENDENT coverage selected:

☐ Employee plus one dependent
☐ Employee plus children
☐ Employee plus family

CHANGE coverage selected:

☐ **ADD** coverage ☐ **DROP** coverage
☐ Employee
☐ 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