



COMPLETE ALL SECTIONS WITH \*\*\* LIST ALL DEPENDENT INFO AND SIGN AND DATE

### Vision Care Enrollment Form

**For Local Use Only**  
Group No.:

(Please print, in ink)

Name (Last, First, Middle Initial) \*\*\* Social Security Number \*\*\*

Home Address \*\*\* City \*\*\* State \*\*\* Zip \*\*\*  
ELMONT UFSD 135 ELMONT ROAD, ELMONT NY 11003

Benefit Fund or Employer Name

Date of Birth \*\*\* Home Phone \*\*\* Work Phone \*\*\*  Male \*\*\*  Female \*\*\*

Please Indicate Coverage Type  Individual  Family \*\*\* You must provide proof documents for all dependents.

If available and you are electing family coverage, list below the names of spouse and unmarried children under 26 years of age. Unmarried, dependent children are eligible for benefits until their 26th birthday. Unmarried children 26 years of age or older, who are incapable of self-support because of mental or physical disability are covered provided that the disability began before the age of 26. Additional spaces can be found on the bottom of this form.

First Name, MI	Last Name	SS#	Relationship	Date of Birth	Full Time Student
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature \*\*\* signature is required on the line above Date \*\*\* DATE ABOVE

**Note:** Members who defraud or attempt to defraud the NYSUT Group Benefits Plan or who knowingly give false or misleading information are subject to a penalty which may include suspension of eligibility for all Plan benefits. Members are responsible for notifying the Plan Office of any changes in marital and/or dependent status by submitting a Change of Status Card which is available from the Plan office.

CONTINUE DEPENDENT INFORMATION HERE IF NEEDED- you must provide proof documents for all dependents.

First Name, MI	Last Name	SS#	Relationship	Date of Birth	Full Time Student
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No