VISION SERVICE PLAN

Enrollment Form for COBRA Applicants

Employer or Group Name:	Group Number:	Effective Date:

EMPLOYEE INFORMATION:

Name (Last, First, Middle Initial	Daytime Telephone Number	Sex ☐ Male ☐ Female
Mailing Address (Number, Street, City, State, Zip)		

Social Security Number	Employee Number	Birth Date (Month/Day/Year	Marital Status ☐ Married ☐ Single

ELIGIBLE FAMILY MEMBERS (Please list all dependents to be covered. Attach separate listing if more dependents exist. Dependents must be eligible as income tax dependents.)

Name (Last, First, Middle Initial):	Social Security Number:	Birthdate (Month/Day/Year)	Sex	Relationship to Employee
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	

Dependent Eligibility Information:

If you have listed a dependent child over the age of 19 years, please answer the questions about your dependents:

1. Married ☐ Yes ☐ No
2. Income Tax Dependent? ☐ Yes ☐ No
3. Incapacitated or Disabled? ☐ Yes ☐ No
4. Full-time student an accredited school? ☐ Yes ☐ No

SIGNATURE: **DATE:**

X _____ _____

COBRA ENROLLMENT IF OTHER THAN EMPLOYEEE:

State COBRA qualifying event: _____Effective Date: _____

Relationship to above named subscriber ☐ Spouse ☐ Over-aged Dependent ☐ Other

Name (Last, First, Middle Initial)	Social Security Number	Birth Date (Mo/Day/Year)	Sex ☐ Male ☐ Female

List dependents to be covered under COBRA benefits:

Name (Last, First, Middle Initial)	Social Security Number	Birth Date (Mo/Day/Year)	Sex
Dependent			☐ Male ☐ Female
Dependent			☐ Male ☐ Female

SIGNATURE: **DATE:**

X _____ _____

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED.

RETURN COMPLETED FORM TO: Seattle Housing Authority
Human Resources
POB 19028
Seattle, WA 98109-1028