ENROLLMENT/CHANGE/WAIVER FORM

Employer Group Name: BRYANT UNIVERSITY Group Number: V0684

1. TO ENROLL (Complete Section 1)

Employee Name: _____ Gender: _____ (M/F) Marital Status: _____ (S/M)

Street Address: _____ City_____ State_____

Date of Birth: _____ Social Security #: _____

Date of Hire: _____ If this is for a change, date of change: _____

Electing Coverage for: ☐ Myself ☐ Employee & 1 Dependent ☐ Family

If declining coverage for yourself or dependents, complete section 2

DEPENDENT COVERAGE INFORMATION (List dependents to be covered)

Print Full Legal Name (Last, First, MI)	Date of Birth (mo. day yr.)	ADD	DROP	RELATIONSHIP
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
_____	_____	☐	☐	_____
		☐	☐	

2. TO WAIVE COVERAGE (Complete Section 2 below)

Declining coverage for: ☐ Myself ☐ Spouse ☐ Child(ren)

Important! If declining coverage on yourself or dependents please complete one of the reasons below.
I have been given the opportunity to apply for this vision coverage offered by my employer and have decided not to accept this offer for myself or my dependents because:

☐ I have coverage elsewhere. Provide name of insurance company: _____

☐ Other- Reason: _____

If electing coverage provided by my employer, I authorize deductions from my earnings of the required contributions, if any, toward the cost of this insurance.