MEMBER BENEFITS nysut

Vision Care Enrollment Form

(Please print, in ink)

For Local Use Only
Group No.:

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

Home Address City State Zip

Benefit Fund or Employer Name

Date of Birth Home Phone Work Phone ❒ Male ❒ Female

Please Indicate Coverage Type ❒ **Individual** ❒ **Family**

If available and you are electing family coverage, list below the names of spouse and unmarried children under 25 years of age. Unmarried, dependent children ages 19 to 25 are eligible for benefits only if they are full time students. Unmarried children 19 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 19. Additional spaces can be found on the back of this form.

First Name, MI	Last Name (if different)	Relationship	Date of Birth	Full Time Student
		❒ Spouse ❒ Daughter ❒ Son		❒ Yes ❒ No
		❒ Spouse ❒ Daughter ❒ Son		❒ Yes ❒ No
		❒ Spouse ❒ Daughter ❒ Son		❒ Yes ❒ No
		❒ Spouse ❒ Daughter ❒ Son		❒ Yes ❒ No

Signature **Date**

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.