BlueCross Blue Shield of Illinois
VISION BENEFIT

Enrollment & Change Form

Administrative Offices: 701 E 22nd St, Lombard, IL 60148

___ New Enrollment ___ Change ___ Open Enrollment

Employer/Employee Section

EMPLOYER: Illinois Wesleyan University		GROUP/ACCOUNT #F026081		
LAST NAME	FIRST NAME	MIDDLE INITIAL		
SOCIAL SECURITY NUMBER	GENDER	DATE OF BIRTH	DATE OF HIRE	
HOME ADDRESS	CITY	STATE	ZIP	PHONE

Benefit Selection

ENROLLMENT	CHANGE *(mark reason for change)*	CANCEL COVERAGE
Effective Date: _____	Effective Date: _____	Effective Date: _____
___ Employee Only	___ Married	
___ Employee + Child(ren)	___ Birth/Adoption	
___ Employee + Spouse	___ Widowed	
___ Employee + Family	___ Divorced	
	___ Address Change	

Covered Dependent(s)

FIRST & LAST NAME	SSN	DATE OF BIRTH	RELATIONSHIP	GENDER

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work, my coverage may lapse or terminate.

EMPLOYEE SIGNATURE _____ DATE _____