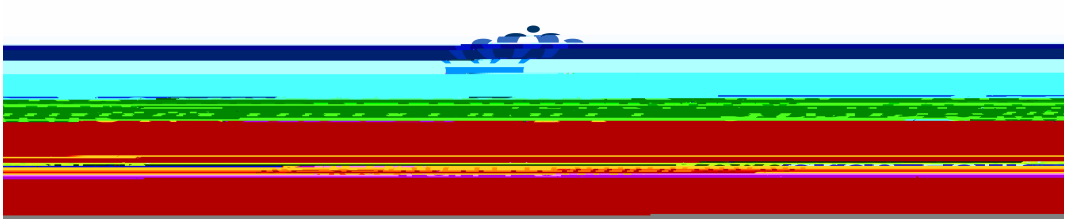

VISION SERVICE PLAN

ENROLLMENT- C HANGE FORM – Vision Care

Name of Employer Old Dominion University Research Foundation

Employee Name_____ U_____
Print Last name, first name, middle initial

Employee Only Coverage
CHANGE coverage

Waive Employee coverage
Waive Dependent Coverage

DEPENDENT coverage selected:

Employee plus one dependent
Employee plus children
Employee plus family

CHANGE coverage selected:

ADD coverage DROP coverage
Employee
Dependent Spouse
Dependent Child(ren)

_____ _____ / _____
1. Spouse Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____ / _____
2. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____ / _____
3. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____ / _____
4. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____
Employee Signature Date

_____