

Idaho Community Vision Plan Employee Application

2824 Poleline Road, Suite A
 Pocatello, ID 83201
 Phone (208) 238-1171 Fax (208) 238-1141

Enrollment Form Complete Sections I and II

Change Form Complete Section I, II, III as Needed

I. Employee Information (Please Print)					
Name (First)	(Middle)	(Last)	Social Security Number	Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address			City, State, Zip		
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Two					
Employer			Employee Date of Hire	Enrollee's Effective Date	

II. Dependent Information (List all family members you wish to enroll.)					
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	Dependent's Name (First, MI, Last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.

III. Change Requests	
Change current enrollment due to: <input type="checkbox"/> Loss of previous coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Event _____	
Change my name from:	To:
Change my address to:	

I hereby apply for the group coverage for which I may be eligible. I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been Approved.

Signature _____ Date _____