Voluntary Vision Program Enrollment Form
Lansing Community College
Effective: 01/01/2018 – 12/31/2018

INSTRUCTIONS:

This form should be legibly printed or typed in black or blue ink. Please check "☑" all applicable boxes and enter the corresponding information requested. If more space is needed than provided, attach additional sheet(s) and reference the question.

PRIMARY MEMBER INFORMATION: (Must complete all fields)

Name of Employee/Enrollee:	Gender: ☐ Male ☐ Female	Date of Birth:

Address:	City:	State:	ZIP:	Phone:

Social Security Number:	email:

DEPENDENT INFORMATION: (If more than 5 dependents, please use back of sheet)

Name of Dependent:	Date of Birth:	Gender:	Relationship:	If the child is over age 26 is the child?
	____/____/ ____	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Permanently and Totally Disabled
	____/____/ ____	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Permanently and Totally Disabled
	____/____/ ____	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Permanently and Totally Disabled
	____/____/ ____	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Permanently and Totally Disabled
	____/____/ ____	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Permanently and Totally Disabled

I hereby elect the following coverage:

Coverage	Premium
☐ Employee Only	$99.00 per plan year
☐ Employee + 1 Dependent	$169.00 per plan year
☐ Employee + 2 or more Dependents	$259.00 per plan year

Please return this completed enrollment form, with your full payment to:

Heritage Vision Plans, Inc.
Attn: LCC Voluntary Vision Enrollment
One Woodward Avenue, Suite 2020
Detroit, MI 48226

For assistance with completing this enrollment form, please call: **800.252.2053**

I understand that by signing this enrollment form, I am electing the vision plan effective 01/01/2018 – 12/31/2018. Furthermore, I understand I may not make changes to these elections during the plan year.

I verify that any dependents that I may have enrolled in my benefit plan are eligible according to the provisions of the insurance programs of Lansing Community College. I certify and agree to provide proof, upon request, and I agree to remove my dependents from coverage on the date they no longer meet these eligibility requirements. The information supplied by me or on my behalf is true and accurate to the best of my knowledge. If I have supplied false information, or enrolled dependents who are not eligible for coverage, I understand the insurance carrier has the right to take corrective actions. I understand that Heritage reserves the right to amend, modify, or terminate plans at any time.

I certify that I will make payments as required. I authorize recovery of any payments made on behalf of an ineligible individual; or recovery of any payments to which I or my dependents are not entitled.

Signature:________________________________Date:_____________

PAYMENT

Amount Enclosed: $______________________________