



City of Newport News
 Employees' Retirement and Benefits Office
 2400 Washington Avenue
 Newport News, VA 23607

Vision Insurance Enrollment & Change Form

New Enrollment

Benefit Option Change

Employee Name:	
SSN/EID:	
Date of Birth:	
Date of Hire:	
Department:	
Effect Date of Insurance:	

Type of Coverage Selected:		
_____ Employee	_____ Employee + 1	_____ Family
Last Name (If Different), First	Relationship	Birthdate MM/DD/YY
<i>spouse</i> 2		
<i>dependent</i> 3		
<i>dependent</i> 4		
<i>dependent</i> 5		

I agree to have deductions taken out of my City payroll changed or canceled during open enrollment.

SIGNATURE _____ **DATE** _____

- If you choose the plan for yourself, complete the form and check “**Employee**”.
- If you choose to cover yourself and one family member such as a spouse or dependent child, check “**Employee +1**” and list the name of the spouse or dependent.
- If you choose to cover yourself and 2 or more family members, check “**Family**” and list all family members to be covered.