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**VBA Vision  
 Small Group  
 Enrollment Change Form**

<b>EMPLOYER NAME:</b>	<b>CLIENT ID #:</b>
<b>EFFECTIVE DATE:</b>  <small>Enrollments effective the 1<sup>st</sup> day of the month        Terminations effective the last day of the month</small>	<b>VBA Plan (Select One)</b> <input type="checkbox"/> Option 1 (009) <input type="checkbox"/> Option 3 (2713) <input type="checkbox"/> Option 2 (2712) <input type="checkbox"/> Option 4 (4146)

EMPLOYEE INFORMATION					
Last Name	First Name	MI	Social Security		
Address – Street		New Address: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Address – City State and Zip					
Home Phone:	Work Phone	Email		Date of Hire	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

ENROLLMENT / CHANGE / TERMINATION INFORMATION
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Covered Individual(s)						Check Only One			
	Last Name	First Name	Gender	Date of Birth	Social Security Number	Add	Change	Term	
Employee	<i>Please indicate action to right for employee listed above</i>								
Spouse <sup>A</sup>			<input type="checkbox"/> Male <input type="checkbox"/> Female						
Child <sup>B</sup>			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled+						
Child <sup>B</sup>			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled+						
Child <sup>B</sup>			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled+						
Child <sup>B</sup>			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled+						

<sup>A</sup> Includes Domestic Partners. Evidence of domestic partnership must be provided at time of enrollment.  
<sup>B</sup> Dependent children may be covered until the end of the month attainment of age 26.

JUSTIFICATIONS / SIGNATURES
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Justification: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Initial Eligibility <input type="checkbox"/> Life Status Change Event (Explain Below) <input type="checkbox"/> Other (Explain Below)  Explanation:	+Disability Effective Date: ____/____/____ Reason: _____ _____ _____
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EMPLOYEE SIGNATURE: _____	DATE ____/____/____
EMPLOYER SIGNATURE: _____	DATE ____/____/____