KLDTA - 7300
ENROLLMENT/CHANGE FORM

EMPLOYEE NAME LAST	FIRST	MIDDLE	SS#	
HOME ADDRESS		CITY	STATE OR PROVINCE	ZIP
BIRTHDATE: MONTH: DAY: YEAR:		SEX :	DESIRED COVERAGE	
DO YOU OR YOUR SPOUSE HAVE ANY OTHER VISION INSURANCE AT PRESENT?				

IF YOU HAVE ANSWERED "YES" TO THE ABOVE QUESTION, COMPLETE THE FOLLOWING WHERE APPLICABLE.

Name of Enrollee in Other Plan:
Enrollee's Place of Employment:
Name of Other Insurance Company:
Type of Coverage: Individual Family

DEPENDENT LIST (TO BE COMPLETED ONLY IF YOU ARE TAKING FAMILY COVERAGE)

Last Name	First Name	Date of Birth	Relationship	Sex	Social Security Number	Student
1.						
2.						
3.						
4.						
5.						
6.						

ENROLLEE STATEMENT

I swear that all above information is true and complete

SIGNATURE _____ DATE _____

TO BE COMPLETED BY A TRUST FUND REPRESENTATIVE

Date of Employment: _____

Effective Date: _____

ENROLLMENT TYPE

NEW _____
CHANGE _____
TERMINATE _____
RETIRE _____

TRUST FUND REPRESENTATIVE _____ **DATE** _____

(Signature)