RESET FORM

STATE OF DELAWARE
OFFICE OF PENSIONS

VISION APPLICATION OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Effective Date: _____

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

☐ New Enrollment	☐ Termination/Refusal	☐ Change of Dependents
☐ Coverage Change	☐ Address Change	☐ Name Change

B. PLEASE SELECT THE COVERAGE OPTION:

☐ Individual	☐ Individual & Child(ren)
☐ Individual & Spouse	☐ Family

C. PLEASE SELECT ONE VISION PLAN:

☐ High

☐ Low

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last, First, Middle Initial):		Date of Birth:
Home Address:			Home Phone:
City:	State:	Zip Code:	Work Phone:

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Last Name	First Name	Date of Birth	SSN
Self			
Spouse			
Child fulltime student ☐ disabled ☐			
Child fulltime student ☐ disabled ☐			
Child fulltime student ☐ disabled ☐			

X_____ _____

SIGNATURE **DATE**

The vision plan is a **binding election**. Once enrolled, you may not drop coverage during the plan year unless you experience a qualifying event. **Please note:** ***The enrollment form is for the Pension Office's use only and will not be used for any external purpose.***

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