State of Delaware
Office of Pensions

VISION APPLICATION OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO PENSION.FORMS@DELAWARE.GOV

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: _____ Date of Birth: _____
Last Name: _____ First Name: _____ MI: ___
Phone: _____ Work Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Personal Information

Last Name: _____ First Name: _____
Birth Date: _____ SSN: _____

Spousal Information

Last Name: _____ First Name: _____
Birth Date: _____ SSN: _____

860 SILVER LAKE BLVD., SUITE 1 - MCARDLE BUILDING - DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 - TOLL FREE: (800) 722-7300 - FAX: (302) 739-6129
EMAIL: PENSIONOFFICE@DELAWARE.GOV - WWW.DELAWAREPENSIONS.COM

Vision Application Revised January 2026 - **#379**

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Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

By my signature below, I hereby certify the benefit election and statements made on this form are true and my choice. I have completed the required forms necessary to enroll in the vision election noted. I understand that by completing and signing the required forms, I am affirming that any dependents noted are eligible dependents as defined by the State's Eligibility and Enrollment Rules (found on the SBO website Section 2.0). I understand this is a binding election. Once enrolled, I may not drop or change coverage during the plan year unless I experience a qualifying event that warrants the change. During the next open enrollment period, I can drop or change my vision election.

_____ _____

Signature Date

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Addendum to Vision Application – Additional Dependents Information

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

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Dependent Information

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

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