Hopkins County Board of Education

APPLICATION FOR COBRA VISION INSURANCE (Please Print or Type)

EMPLOYEE'S NA	ME:				
	LAST	F	IRST	MIDDLE INITIAL	
ADDRESS:					
CITY		STATE		ZIP CODE	
SOCIAL SECURIT	Y NUMBER:			_	
MALE	FEMALE	_ DATE OF BIRTH:	: <u>-</u> _		
EFFECTIVE DATE	::	-			
COVERAGE STATUS DESIRED:EMPLOYEE ONLY					
		EMPLOYEE & ALL DEPENDENTS			
THE MONTHLY PREMIUM IS $\$7.34$ FOR EMPLOYEE ONLY, AND $\$24.34$ FOR EMPLOYEE AND ALL DEPENDENTS.					
IF DEPENDENT COVERAGE IS CHOSEN, PLEASE LIST ALL ELIGIBLE DEPENDENTS:					
	LAST NAME	FIRST NAME	MIDDLE INIT	BIRTH DATE	
				MO DAY YR	
SPOUSE					
CHILD					
CHILD					
CHILD CHILD					
СПІСИ	(ADD	OTHERS IF NECES	CADV)		
I have elected to take the Vision Cobra Insurance and all premium(s) will be paid to date.					
SIGNATUREDATE					
FOR CENTRAL OFFICE USE ONLY					
EFFECTIVE DATE: DATE SHIPPED TO VSP:					
BENEFITS/FINANCE PERSONNEL:					