MEBS
Better Decisions. Better Healthcare.

CLOMSU

Vision Plan Enrollment Form

Sponsor: Coalition of Labor Organizations at MSU

Employee: ____
Last Name First Name MI

Social Security No.: ______________________ Date of Birth: ____________________

Home Mailing Address: ____

City: __________________________ State: ________ Zip: ______________

Home Phone: ______________________ Work Phone: ____________________

Please check one:

☐ I receive a monthly paycheck from MSU, please payroll deduct my monthly premium

☐ I do not receive a monthly paycheck from MSU, please invoice me quarterly

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Please check one 24-month plan:

☐ Vision Care Direct (VCD)
- ☐ Single Coverage
- ☐ Two Person Coverage
- ☐ Family Coverage

☐ National Vision Administrators (NVA)
- ☐ Single Coverage
- ☐ Two Person Coverage
- ☐ Family Coverage

Dependents: List family members you are covering. First name only – list last name if different from yours.

Spouse: __________________________ Sex: ________ Date of Birth: ______________

Child: __________________________ Sex: ________ Date of Birth: ______________

Child: __________________________ Sex: ________ Date of Birth: ______________

Child: __________________________ Sex: ________ Date of Birth: ______________

I have read and understand the benefits and conditions of participating in the sponsored plan I am enrolling in. I understand that my physician or service provider may disclose my health information and the health information of my covered dependents to MEBS for the purposes of treatment and payment or other health care operations as permitted by federal law. I also understand any health information received by MEBS will be used and/or disclosed only for the purposes of treatment, payment, and health care operations permitted by federal law. I agree to pay MEBS monies for premiums for 24 months of coverage either directly or through payroll deductions as I have selected above. I further understand it is my responsibility to notify MEBS of any change in my enrollment status or any dependent's eligibility for coverage.

Employee Signature: ______________________________ **Date:** ______________

Mail this form to:

MEBS, Inc.
3809 Lake Eastbrook Blvd
Grand Rapids, MI 49546

PH: (800) 968-9682
FAX: (616) 458-3884