VISION SERVICE PLAN
ENROLLMENT FORM

EMPLOYER INFORMATION (To be completed by Employer)

GROUP NAME			GROUP NUMBER
CALIFORNIA LUTHERAN UNIVERSITY			**903154 0001**
ADDRESS	DATE OF HIRE	EFFECTIVE DATE	
60 W. OLSEN ROAD, THOUSAND OAKS, CA 91360			

EMPLOYEE INFORMATION (To be completed by Employee)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER

STREET	DATE OF BIRTH

CITY	STATE	ZIP	SEX	MARITAL STATUS

DEPENDENT INFORMATION (Please list only eligible dependents you wish to enroll)

	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH
SPOUSE					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					

EMPLOYEE AUTHORIZATION (Signature required.)

On behalf of myself and my eligible dependents, I hereby apply for coverage under the Plan offered through my employer group and agree to and understand the following:

1. My employer may deduct from my earnings the employee contributions required to cover my share of the premium, if any.
2. The Company or its designee shall have access and use of my medical records or the medical records of my dependents for purposes reasonable related to the provision of services under this Plan, provided such access is permitted by law.
3. Any material omissions or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my dependent's coverage.
4. Coverage shall not begin until acceptance of this application by the Company.

SIGNATURE: ______________________________ **DATE:** ______________