



# DIocese OF OWENSBORO

Anthem Blue Cross Blue Shield  
*Blue View Vision<sup>SM</sup> Enrollment Form*



## I. Employee Information (please print clearly):

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male: ☐ Female: ☐

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## II. Check the Appropriate Boxes

☐ Employee Only \$ \_\_\_\_\_

☐ Employee + Spouse \$ \_\_\_\_\_

☐ Employee + Child(ren) \$ \_\_\_\_\_

☐ Employee + Family \$ \_\_\_\_\_

☐ New Hire

☐ Change of Status

☐ Open Enrollment

### Reason for change in status:

☐ Termination

☐ Other Insurance

☐ Marriage

☐ Death

☐ Newborn Child

☐ Divorce

☐ Last Name/Address Change

☐ Adoption/Legal Custody of Child

☐ Legal Custody of Parent

☐ Dependent Child Married/Reached Age Limit

## III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	DOB	Social Security #	Sex
Spouse:	_____	_____	____/____/____	_____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child:	_____	_____	____/____/____	_____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child:	_____	_____	____/____/____	_____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child:	_____	_____	____/____/____	_____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child:	_____	_____	____/____/____	_____	<input type="checkbox"/> M/ <input type="checkbox"/> F

**\*\*I agree to continue enrollment in the vision plan for a period of 12 months. \_\_\_\_\_ (please initial)**

**\*\*I decline coverage in the vision plan \_\_\_\_\_ (please initial)**

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Employer Use Only:

Location #: \_\_\_\_\_

Location Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_