SANTA MONICA COLLEGE
VISION SERVICE PLAN

ENROLLMENT / CHANGE FORM

☐ New Enrollment ☐ Add/Delete Dependent ☐ Marital Status Change ☐ Terminate Enrollee Coverage

PRIMARY ENROLLEE INFORMATION

First Name	Last Name		Middle Initial
Mailing Address (Street)	**City**	**State**	**Zip Code**

Social Security Number	Date of Birth	Gender	Marital Status
	/ /	☐ Male ☐ Female	☐ Single ☐ Married

DEPENDENT ENROLLEE INFORMATION

Relationship	Dependent First Name *(last name only if different from enrollee)*	Add / Term	Social Security Number	Date of Birth	Male / Female
Spouse/ Domestic Partner		☐ ☐		/ /	☐ ☐
Children		☐ ☐		/ /	☐ ☐
		☐ ☐		/ /	☐ ☐
		☐ ☐		/ /	☐ ☐
		☐ ☐		/ /	☐ ☐

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contact.

Signature of Enrollee:_____ Date:_____

Employee Benefits Office Use Only

Coverage Effective Date: 09 / 1 / 2026 **Processed By:** _____