EMPLOYER NAME: _____

ACCOUNT # / CLIENT ID #: _____

VBA Plan Select One ☐ **Option 1 (009)** ☐ **Option 2 (2712)** ☐ **Option 3 (2713)** ☐ **Option 4 (4146)**

VBA VISION Enrollment / Change Termination Form

(Revised 11/2016)

Capital Administrators
A Division of Capital Region Benefits
Email: admin1@crbenefits.net
Phone: 717-975-9300
Fax: 717-975-9303

EFFECTIVE DATE

Effective Date: _____ **[VBA Enrollments on the 1st day of the month]** **[VBA Terminations on the last day of the month]**

EMPLOYEE INFORMATION

Last Name	**First Name**	**MI**	**Social Security**	
Address – Street		**New Address:** ☐ Yes ☐ No	**Date of Birth**	**Marital Status:** ☐ Single ☐ Married
Address – City State and Zip				
Home Phone:	**Work Phone**	**Email**	**Date of Hire**	**Gender:** ☐ **Male** ☐ **Female**

ENROLLMENT / CHANGE / TERMINATION INFORMATION

Covered Individual(s)

	Last Name	**First Name**	**Gender**	**Date of Birth**	**Social Security Number**	**Check Only One** Add	Change	Term
Employee								
Spouse [A]			❒ Male ❒ Female					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					
Child [B]			☐ Male ❒ Female ❒ Disabled+					

[A] Includes Domestic Partners. Evidence of domestic partnership must be provided at time of enrollment.

[B] Dependent children may be covered until the end of the month attainment of age 26.

JUSTIFICATIONS / SIGNATURES

Justification: ❒ Open Enrollment
❒ Initial Eligibility
❒ Life Status Change Event (Explain Below)
❒ Other (Explain Below)

Explanation: _____

+Disability Effective Date: ____/____/_____

Reason: _____

_____

_____

EMPLOYEE SIGNATURE: _____ DATE ____/____/_____

EMPLOYER SIGNATURE: _____ DATE ____/____/_____