

***Vision Reimbursement Program
Family Status Change Form***

Employee Name _____ Employee ID# _____

List dependents you are adding to your contract (Spouse, children up to age twenty-five (25) as defined by the IRS)

1. Name _____ Relationship _____ Birthdate _____

Reason for Addition _____ Effective Date of Change _____

2. Name _____ Relationship _____ Birthdate _____

Reason for Addition _____ Effective Date of Change _____

List dependents you are deleting from your contract

1. Name _____ Relationship _____ Birthdate _____

Address _____

Reason for Deletion _____ Effective Date of Change _____

2. Name _____ Relationship _____ Birthdate _____

Address _____

Reason for Deletion _____ Effective Date of Change _____

All Family Status changes must be reported on the Vision Reimbursement Program Family Status Change Form. This form must be returned to the Human Resources Office within thirty (30) calendar days from the qualifying event, and supporting documentation must accompany the Family Status Change Form.

Employee Signature _____ Date _____

Human Resources Authorization _____ Date _____