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Family Vision Enrolment and Change Form

Please complete this form and return it to the Pension & Benefits Office in the department of Human Resources and Employee Relations. Claims cannot be processed for spouses and/or dependants who are not listed.

General Information

If approved, this application enrols me in the family vision program. **Family vision must begin the first of the month. I understand the premium for family vision will be deducted from my pay.**

Last Name	First Name	Initials	Employee Id#

☐ I wish to enroll into family vision effective: _____01_____
Month Day Year

Dependant's to be covered under the family vision benefit

Last Name	First Name	Birth date (mmddyyyy)	Overage Student (Y/N)	Disabled (Y/N)	Gender (M/F)

☐ Effective _____ I wish to **cancel** my family vision coverage. I understand and accept if I cancel family membership in the Vision Care Plan I can reinstate family coverage only in the event of a change in marital status, or if my spouse's coverage at their place of employment ceases.

I understand it is my responsibility to notify the University of any addition or deletion from those I wish covered under the plan. The insurer reserves the right to obtain reimbursement from me for any benefits paid due to error, misrepresentation or lack of notification.

_____ _____
Employee Signature **Date**

York University Pension & Benefits Office, Human Resources and Employee Relations, East Office Building, Suite A,
4700 Keele Street, Toronto ON M3J 1P3, Telephone 416-736-2100 Fax 416-736-5703