BCBS BLUEVISION INSURANCE ENROLLMENT FORM

Nebraska State College System
CHADRON | PERU | WAYNE

Employee Name (print): _____

Effective Date: _____

Enrollment Action (check one):

- ☐ New Hire – Initial Enrollment
- ☐ Add Coverage
- ☐ Decline Coverage
- ☐ Stop Coverage
- ☐ Change Coverage
  - Reason and date of event: _____

Select the Coverage Level (Employee Monthly Premium Cost is Listed):

- ☐ Employee ($4.28/month)
- ☐ Employee and Child(ren) ($10.96/month)
- ☐ Employee and Spouse ($12.18/month)
- ☐ Family ($19.12/month)

Family Members (if covered):

Full Name	SSN	Date of Birth	M	F	Relationship

I authorize my employer to withhold the required premiums from my earnings.

Employee Signature:_____ Date:_____

Submit completed form to Human Resources.

eyemed

Vision Provider Locator
https://eyedoclocator.eyemedvisioncare.com/member/en-us

07/23/2026