



Please Check appropriate box:

- New Enrollment
- Change in Enrollment
- Delete all coverage -
(Employee and Dependents)

VISION SERVICE PLAN

SOCIAL SECURITY No.	EMPLOYEE LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH Mo. DAY YEAR	GENDER M <input type="checkbox"/> F <input type="checkbox"/>
Employee I.D. No.	<input type="checkbox"/> 12thly Employee <input type="checkbox"/> 10thly Employee	<input type="checkbox"/> Employee Only.....\$ 9.24/monthly or \$11.08/tently <input type="checkbox"/> Employee + One Dep.....\$13.50/monthly or \$16.20/tently <input type="checkbox"/> Employee + Family.....\$24.21/monthly or \$29.05/tently			DATE OF HIRE Mo. DAY YEAR

Please List All Eligible Dependents

ADD (A)/ DELETE (D)	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	GENDER
	Spouse/Domestic Partner <i>(Circle One)</i>				M <input type="checkbox"/> F <input type="checkbox"/>
	Children <i>(Include surname if different)</i>				M <input type="checkbox"/> F <input type="checkbox"/>
					M <input type="checkbox"/> F <input type="checkbox"/>
					M <input type="checkbox"/> F <input type="checkbox"/>
					M <input type="checkbox"/> F <input type="checkbox"/>

Please return to the Employee Benefits Department. Do NOT return to VSP.

Important Enrollment Information

- If you enroll in the VSP plan, you are making a two-year commitment. You cannot cancel your coverage until the open enrollment that occurs two years after your initial date of coverage.
- Due to the nature of the coverage, participants who enroll in the vision plan and subsequently dis-enroll, will not be permitted to re-enroll for a minimum of 24 months from the date their vision coverage terminates. The same rule would be applicable to dependents, domestic partners and children of domestic partners.
- Dependents may be covered up to their 24th birthday without regard to student status.
- As the vision plan is included in the District's Flexible Spending Account, premiums for you and your dependents will be deducted on a pre-tax basis. Premiums for domestic partners and children of domestic partners are not eligible for pre-tax treatment.

I hereby apply for coverage under the Vision Service Plan and authorize the District to deduct from my salary the monthly sum necessary to pay the premium due.

Signature _____ Date _____