



**VISION
 SERVICES
 PLAN**

Please Check Appropriate Box:

- New Enrollment Add Dependent Change Plan Terminate Coverage Delete Dependent

BASIC PLAN

- Employee Only.....\$ 9.24/MO or \$11.08/tenthly
 Employee + One Dep.....\$13.50/MO or \$16.20/tenthly
 Employee + Family.....\$24.21/MO or \$29.05/tenthly

PLUS PLAN

- Employee Only.....\$14.89/MO or \$17.80/tenthly
 Employee + One Dep.....\$21.68/MO or \$26.02/tenthly
 Employee + Family\$38.89/MO or \$46.66/tenthly

Employee Information:

Employee Last Name	First Name	M.I.	EMPLID	Pay Group <input type="checkbox"/> Monthly <input type="checkbox"/> Tenthly
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire	

Dependent Information:

Add (A)/
Delete (D)

	Last Name	First Name	M.I.	Date of Birth	Gender
	Spouse/Domestic Partner (Circle One)				<input type="checkbox"/> Male <input type="checkbox"/> Female
	Children (Include Surname if Different)				<input type="checkbox"/> Male <input type="checkbox"/> Female
					<input type="checkbox"/> Male <input type="checkbox"/> Female
					<input type="checkbox"/> Male <input type="checkbox"/> Female
					<input type="checkbox"/> Male <input type="checkbox"/> Female
					<input type="checkbox"/> Male <input type="checkbox"/> Female

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 disenroll, 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.

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: _____