Vision Service Plan

Enrollment Form

1/1/2017 – 12/31/2017

Regular Full-Time and Regular Part-Time Employees and Council Members

☐ I elect vision coverage for myself only
☐ I elect vision coverage for my spouse/domestic partner
☐ I elect vision coverage for my spouse/domestic partner and dependents
The following monthly premium rates apply to dependent vision coverage:
One dependent: $ 1.86 **Two or more dependents**: $12.36

Please list yourself and all dependents you want covered:

	Name	Social Security Number	Date of Birth
Employee			
Spouse/Domestic Partner			

	Name	**Social Security Number**	**Date of Birth**	**Relationship**
Child				
Child				
Child				
Child				

Please sign below to acknowledge your options and authorize a payroll deduction for the applicable premium payment.

Signature	**Date**	**Employee #**