Madison County Commission – 30017339

VISION CARE PLAN

To enroll in the Vision Care Program, you need to complete and return the application below.

Please check one:
- ☐ New Enrollment
- ☐ Add Dependent
- ☐ Drop Dependent
- ☐ Termination of Coverage

Exam: Every 12 Months
Prescription Lenses: Every 12 Months **OR** Contact Lenses: Every 12 Months (in lieu of glasses)
Frame: Every 24 Months

Co-payments: $20 Examination / $20 Materials

I wish to enroll (Please check one):

	Bi-Weekly Premium
☐ Employee Only Coverage	$2.77
☐ Employee + One	$5.82
☐ Employee + Family	$8.92

Please print **your** information below:

Employee Name: _____
(Please print) Last Name First Middle Initial

Employee Social Security Number: _____ DOB: _____

Employee Address: _____

_____

Please complete this section only if adding or dropping dependents

ELIGIBLE FAMILY MEMBERS (List dependents to be enrolled. Attach separate listing if more dependents exist.):				
Name (Last, First, Middle Initial):	Social Security Number:	Birth Date (Month/Day/Year)	Sex	Drop or Add
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	

I authorize payroll deduction for vision coverage and must remain in the program through the plan year unless there is a qualifying event.

_____ _____
Employee's Signature Date