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	$2.88
☐ Employee + One	$6.06
☐ Employee + Family	$9.72

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

Supporting documentation is required for dependents not on LGHIP.

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