Vision Care Plan (VSP) Enrollment & Changes

Employee Information

Name:	SSN:	DOB:	Gender:
Email:		Phone:	
Address:		ZIP:	
City:	State:	Date of Hire:	Hrs Worked:

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

- ☐ NEW ENROLLMENT
- ☐ ADD DEPENDENT
- ☐ DROP DEPENDENT
- ☐ TERMINATION OF COVERAGE
- ☐ **DECLINE COVERAGE**

I wish to enroll *(Please check one)*

- ☐ EMPLOYEE ONLY COVERAGE - *BI-WEEKLY PREMIUM: $2.88*
- ☐ EMPLOYEE + ONE - *BI-WEEKLY PREMIUM: $6.06*
- ☐ EMPLOYEE + FAMILY - *BI-WEEKLY PREMIUM: $9.72*

Please complete this section only if enrolling or dropping dependents

Supporting documentation is required for dependents **not** already enrolled in Local Gov Health / Dental Insurance.

Name (First, Middle Initial, Last)	DOB	Sex	Drop / Add

Employee Acknowledgement and Signature:

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

Employee Signature		Date: