Vision Service Plan
Enrollment/Change Form

Employee Name:________________________ SSN:_________________ DOB:____________

Address:____

City:_______________________ State:________ Zip Code:________

Phone:____________________________ Email:____________________________

Plan Elected:

Single-Certificated Only - No Co-pay	☐
Single-Classified/Certificated - $15.00 Co-pay	☐
Employee + 1 - $15.00 Co-pay	☐
Family - $15.00 Co-pay	☐

Enrollment/Change Reason:

☐ New Enrollment ☐ Open Enrollment ☐ Add Spouse/Dependent/s

☐ Drop Coverage ☐ Delete Spouse/Dependent/s

Name of spouse/dependent:__________________ SS#:__________________ D.O.B.: ______________
Name of spouse/dependent:__________________ SS#:__________________ D.O.B.: ______________
Name of spouse/dependent:__________________ SS#:__________________ D.O.B.: ______________
Name of spouse/dependent:__________________ SS#:__________________ D.O.B.: ______________

Signature:____________________________ Date:__________________________

DISTRICT USE-DO NOT WRITE BELOW THIS LINE

Effective Date:______________________

July 2016