Vision Service Plan
Enrollment & Change Form

Employer Information

Group Name: Regional Center of the East Bay Group Number: 30076272

Date of Hire: _____ Effective Date: / /2021

Employee Information

Name: _____

Social Security Number: _____

Gender: ☐ M ☐ F Date of Birth: _____

Mailing Address: _____

_____

Coverage Election

Cancel VSP-Vision ☐

☐ Employee Only **$3.55 biweekly**

☐ Employee + 1 Dependent **$5.89 biweekly**

☐ Employee + 2 or more Dependents **$10.65 biweekly**

Dependents

		Gender	Date of Birth
Full Name of Spouse or Domestic Partner:			
☐ Add ☐ Delete	_____	☐ M ☐ F	_____
Full Name of Child/Children:			
☐ Add ☐ Delete	_____	☐ M ☐ F	_____
☐ Add ☐ Delete	_____	☐ M ☐ F	_____
☐ Add ☐ Delete	_____	☐ M ☐ F	_____
☐ Add ☐ Delete	_____	☐ M ☐ F	_____

Signature

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and agree to comply with the terms of the group contract.

_____ _____

Employee Signature Date