SANTA ROSA JUNIOR COLLEGE

VISION SERVICE PLAN

FACULTY EMPLOYEES AND 10-MONTH EMPLOYEES

NAME: _____

EFFECTIVE DATE: _____

SSN: xxx-xx-_____

As part of an agreement reached between the District and the All Faculty Association employee group, the District will pay the Vision Service Plan premium for employee-only coverage. Employees will be allowed to enroll their dependents at the employee's expense.

Please indicate your choice below:

☐ I do not have any dependents to enroll at this time. I understand that the District will pay the employee-only coverage on my behalf.

☐ I elect to add my dependent(s) on the District vision plan at my own expense. I understand that a deduction of $15.48 will be deducted from my paycheck each month (Cost is for 1.0 FTE employees. If you work less than 1.0 FTE the deduction will be pro-rated).

List dependents to be covered here:

Name	Relationship	SSN
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I elect to waive vision coverage for my dependents. I understand that the District will continue the employee-only coverage on my behalf.