SANTA ROSA JUNIOR COLLEGE

VISION SERVICE PLAN (VSP)
FACULTY AND 10-MONTH EMPLOYEES

NAME: _____

EFFECTIVE DATE: _____

Employee ID:_____

The District will pay the Vision Service Plan premium for employee-only coverage. (If you work less than 1.0 FTE the District will pay a portion of the premium and you will pay a portion of the premium). Employees will be allowed to enroll their dependents at the employee's expense.

Please indicate your choice below:

☐ I elect to enroll in coverage for myself only.

☐ I choose to waive vision coverage for myself.

☐ I elect to add my dependent(s) on the District vision plan at my own expense. I understand that a deduction of $14.24 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. If you're dropping dependents from your plan, please list the dependents to be dropped here:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____