



## VISION SERVICE PLAN (VSP)

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 \$11.53 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). Faculty and 10-month employees will have a payroll deduction of \$13.84.

List dependents to be covered here:

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