# Vision Service Plan

## Enrollment Form

| Group Name: City of Alameda | | Effective Date: | |
|---|---|---|---|
| Employee Info | Social Security No. | Sex (M/F) | Date of Birth |
| | Last Name | First Name | Middle Initial |
| | Address | City | State / Zip |

| Coverage Info | Check Box to indicate desired coverage | 2019 Monthly Vision Rates | |
|---|---|---|---|
| | ☐ | **Single** | **$ 7.80** |
| | ☐ | **Two Party** | **$ 15.10** |
| | ☐ | **Family** | **$ 24.00** |

| Add/ Delete | Dependent Info | Last Name | First Name | Middle Initial | Sex (M/F) | Date of Birth |
|---|---|---|---|---|---|---|
| | Spouse | | | | | |
| | Child | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

I authorize the City of Alameda to deduct the VSP premium (including any future increases) from my wages.

_____ _____

Employee Signature Date

Return completed form to Human Resources