



Vision Service Plan

2021 Enrollment/ Change Form

Group Name: City of Alameda		Effective Date: January 1, 2021				
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			2021 Monthly Vision Rates		
	<input type="checkbox"/>			CANCEL for 2021 Plan Year		
	<input type="checkbox"/>			Single	\$ 7.80	
	<input type="checkbox"/>			Two Party	\$ 15.10	
	<input type="checkbox"/>			Family	\$ 24.00	
Add/ Delete	Dependent Info	Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth
	Spouse					
	Child					
<p>I authorize the City of Alameda to deduct the VSP premium (including any future increases) from my wages.</p> <p>_____</p> <p>Employee Signature _____ Date</p>						

Return completed form to Human Resources