



## Vision Service Plan 2022 Enrollment/ Change Form

<b>Group Name: City of Alameda</b>		<b>Effective Date: January 1, 2022</b>				
<b>Employee Info</b>	Social Security No.	Sex (M/F)	Date of Birth	Phone Number		
	Last Name	First Name	Middle Initial			
	Address	City	State	Zip		
<b>Coverage Info</b>	<b>Select Level of Coverage</b>		<b>2022 Monthly Premium</b>			
		Cancel Coverage	N/A			
		Employee Only	\$7.80			
		Two Party	\$15.10			
	Family Coverage (3 or More)	\$24.00				
<b>Name (Last, First, M.I.)</b>		<b>Relationship Code*</b>	<b>Gender First Name</b>	<b>Date of Birth (mm/dd/yyyy)</b>	<b>Social Security Number</b>	<b>Action</b>
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
			F M Nonbionary			Add Delete
<p>*Relationship Codes: S – Spouse, DP – Domestic Partner, NC – Natural Child, SC – Step Child, AC – Adopted Child, DPC – Domestic Partner, PCR – Parent Child Relationship</p>						
<p>I authorize the City of Alameda to deduct the VSP premium (including any future increases) from my wages.</p>						
<p>_____</p> <p><b>Employee Signature</b></p>			<p>_____</p> <p><b>Date</b></p>			

Return completed form to Human Resources