City of Alameda | vsp vision

Vision Service Plan

2025 Enrollment/Change Form

Group Name: City of Alameda			Effective Date: January 1, 2024	
Employee Info	Social Security No.	Sex (M/F)	Date of Birth	Phone Number
	Last Name	First Name	Middle Initial	
	Address	City	State	Zip

Coverage Info		Select Level of Coverage	2024 Monthly Premium
		Cancel Coverage	N/A
		Employee Only	$7.80
		Two Party	$15.10
		Family Coverage (3 or More)	$24.00

Name (Last, First, M.I.)	Relationship Code*	Gender First Name	Date of Birth (mm/dd/yyyy)	Social Security Number	Action
		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

*Relationship Codes: S – Spouse, DP – Domestic Partner, NC – Natural Child, SC – Step Child, AC – Adopted Child, DPC – Domestic Partner, PCR – Parent Child Relationship

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

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Employee Signature **Date**

Return completed form to Human Resources