You never know where your eyes will take you…

JACKSON COUNTY

GROUP VISION ENROLLMENT / CHANGE FORM

Group - Jackson County **Group # 12 022378 0002**

SECTION I – EMPLOYEE ENROLLMENT AND COVERAGE ELECTION		
Member Name (First, MI, Last)	Social Security Number	Date of Birth
Street Address City State Zip	Telephone	Effective Date (for office use only)
Email Address	Coverage Selected ☐ Member Only ☐ Member + Children ☐ Member + One ☐ Family (employee plus spouse and dependents(s))	

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widow/Widower

Reason for Completing this From

☐ New Hire ☐ Late Enrollment ☐ Marriage / Birth / Adoption ☐ Terminate Coverage for one/all dependents ☐ Part/Full-Time Change ☐ Open Enrollment

Date of Event Change: ________________________ ☐Special Enrollment/Loss of Coverage - Date Coverage Lost: ________________________

SECTION II – ELIGIBLE DEPENDENT INFORMATION

Name (First, MI, Last)	Relationship	Social Security No.	Date of Birth	Gender
Spouse:	☐Spouse (lawful) ☐Other:			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female

SECTION III - PLAN SELECTION

☐ PLAN A	Plan Frequency 24 / 24 / 24	☐ PLAN C	Plan Frequency 12 / 12 / 12
Co-Pay:	$10 Exam / $25 Materials	Co-Pay:	$10 Exam / $25 Materials
Allowances:	$130.00 Retail Frame or $130.00 Elective Contact Lenses	Allowances:	$130.00 Retail Frame or $130.00 Elective Contact Lenses
**** Plan A pays for exam, frames and lenses every 24 months***		**** Plan C pays for exam, frames and lenses every 12 months***	

SECTION IV – SIGNATURE TO ELECT COVERAGE OR SIGNATURE TO DECLINE COVERAGE

Elect: The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings (pre-tax if applicable). I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments, this auth will be used for verification of benefit eligibility and claim processing. This consent is subject to revocation at any time through a written submission to VSP.

Decline: I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.

☐ I HAVE OTHER COVERAGE

☐ I DO NOT HAVE OTHER COVERAGE

Employee Signature	Date	Employee Signature	Date

Note: This application does not guarantee coverage