County of Santa Barbara

VISION SERVICE PLAN ENROLLMENT FORM

Employee Name: ____

Employee Social Security #: ______________________________________

Cost per Pay Period

Employee only:	$ 3.21
Employee + one:	$ 4.62
Employee + family:	$ 8.29

Are you covering dependents (circle one)? Yes No

If yes, list name and relationship of each:

Dependent Name	Date of birth MM / DD / YY	Relationship (spouse/child)

Frequency of Services		**Copay**
Exam:	Every 12 months	$10.00
Lenses:	Every 24* months	
Frames:	Every 24 months	

* If the prescription for new lenses differs from the most recent by an axis change of 20 degrees or a .50 diopter sphere or cylinder change and the new prescription improves visual acuity by at least one line on the standard eye chart, lenses will be replaced at a 12 month frequency.

Coverage should begin on the first day of ____________________, ______________
Month Year

____ ____________________
Signed Date