

County of Santa Barbara



CHANGE FORM - VISION SERVICE PLAN (SBCERS)

Retiree's Name: _____

Retiree's Social Security #: _____

I decline Vision Plan coverage for myself and all dependents, if any, or

Change my coverage as follows:

<u>Plan Type</u>	<u>Coverage Code</u>	<u>Cost</u>
<input type="checkbox"/> Retiree Only	1751	\$6.95
<input type="checkbox"/> Retiree + one	1752	\$10.01
<input type="checkbox"/> Retiree + family	1753	\$17.96

List individuals to add/drop:

Name	Date of Birth MM/DD/YY	Relationship	Add	Drop
		Self		
		Spouse		
		Child		
		Child		
		Child		

Changes should begin on the first day of: _____, _____
Month Year

 Retiree's Signature

 Date