



## VISION SERVICE PLAN ENROLLMENT FORM (SBCERS)

Retiree's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I am enrolling in VSP.

<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 covered dependents:

Name	Date of Birth MM/DD/YY	Relationship
		Spouse
		Child
		Child
		Child
		Child

Frequency of Services

Exam: Every 12 months  
 Lenses: Every 24\* Months  
 Frames: Every 24 Months

Co-Pay

} \$10.00

*\*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 12 month frequency.*

I am declining enrollment in VSP at this time.

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

\_\_\_\_\_  
 Retiree's Signature

\_\_\_\_\_  
 Date