CEC community eye care

Vision Plan

For Employees of Union County Government

Employee Name: _____

Date of Birth: _____ Gender: _____ Telephone _____

Mailing Address: _____

City: _____State:_____ Zip: _____

Email Address: _____

Coverage Type	☐ 150 Plan		☐ 200 Plan	
☐ Employee Only	$3.65	Bi-Weekly	$5.31	Bi-Weekly
☐ Employee + One	$7.07	Bi-Weekly	$10.25	Bi-Weekly
☐ Employee + Family	$10.72	Bi-Weekly	$15.48	Bi-Weekly

☐ I do not wish to participate in the vision plan.

Family Members (please list if enrolling for Employee + One or Family)

Name	**Relationship**	**Date of Birth**	**Gender**	**Add**	**Term**
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	☐	☐

I hereby apply for enrollment in the Community Eye Care Vision Plan for a minimum of twelve (12) months (or until the beginning of the next plan year). I authorize my employer to deduct the membership fees from my earnings. I also authorize any changes or terminations listed above.

_____ _____

Employee Signature Date

FOR BENEFITS MANAGERS USE ONLY

☐ **NEW ENROLLMENT** Benefit Effective Date _____ Employee ID #_____ *(please do not use Social Security #s)*

☐ **CHANGE REQUESTED** (*Check all that apply)* ☐ Reinstate Coverage ☐Name ☐ Address ☐ Telephone ☐Group Plan ☐ Add/Remove Dependent(s)

Effective Date of Change _____Reason _____

☐ TERMINATION Effective Date of Termination _____Reason _____

Reason Descriptions: OE (Open Enrollment) QE (Qualifying Event) NLE (No Longer Employed) RT (Retired) LOA (Leave of Absence) DE (Deceased)