



Vision Service Plan Enrollment Form

Group Name: City of Alameda		Effective Date:					
Employee Info	Social Security No.	Sex (M/F)		Date of Birth			
	Last Name Initial	First Name		Middle			
	Address Zip	City		State			
Coverage Info		Check Box to indicate desired coverage			2012 Monthly Vision Rates		
		<input type="checkbox"/>			Single	\$ 7.13	
		<input type="checkbox"/>			Two Party	\$ 13.78	
		<input type="checkbox"/>			Family	\$ 21.91	
Add/ Delete	Dependent Info	Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth	
	Spouse						
	Children						
<p>I authorize the City of Alameda to deduct the VSP premium (including any future increases) from my wages.</p> <p>_____</p> <p>Employee Signature _____ Date</p>							

Return completed form to Human Resources