



## Vision Service Plan Enrollment Form

<b>Group Name:</b> City of Alameda		<b>Effective Date:</b>					
<b>Employee Info</b>	Social Security No.	Sex (M/F)		Date of Birth			
	Last Name	First Name		Middle Initial			
	Address	City	State	Zip			
<b>Coverage Info</b>		Check Box to indicate desired coverage			<b>2014 Monthly Vision Rates</b>		
		<input type="checkbox"/>			<b>Single</b>	<b>\$ 7.40</b>	
		<input type="checkbox"/>			<b>Two Party</b>	<b>\$ 14.30</b>	
		<input type="checkbox"/>			<b>Family</b>	<b>\$ 22.70</b>	
<b>Add/ Delete</b>	<b>Dependent Info</b>	<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Sex (M/F)</b>	<b>Date of Birth</b>	
	Spouse						
	Child						
<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 <span style="float: right;">Date</span></p>							

Return completed form to Human Resources