VSP SIGNATURE CHOICE PLAN ENROLLMENT FORM

County of San Joaquin - Retirees

_____ _____ ***SS#:*** _____/_____/_____

(Last Name) *(First Name)*

Date of Birth: _____/_____/_____ ***Phone Number:*** (_____) _____-_____

Address: _____

(Street Address)

_____ _____ _____

(City) *(State)* *(Zip Code)*

Email: _____

I elect coverage for:

Retiree Only _____ Retiree + One Dependent* _____ Family* _____

** If you are electing coverage for one dependent or family, please complete Dependent Information below.*

Dependent Information:

NAME: _____ _____ _____ ____/____/____ _____

Last **First** **Social Security #** **Date of Birth** **Spouse/Partner**

NAME: _____ _____ _____ ____/____/____ _____

Last **First** **Social Security #** **Date of Birth** **Child – M/F**

NAME: _____ _____ _____ ____/____/____ _____

Last **First** **Social Security #** **Date of Birth** **Child – M/F**

By signing this form, I authorize the San Joaquin County Employees' Retirement Association (SJCERA) to deduct from my monthly retirement allowance and remit on my behalf to the insurer the monthly premium amount applicable for the number of individuals covered by my enrollment in the Signature Choice vision care plan offered by Vision Service Plan. I authorize these deductions to continue unless and until I notify SJCERA in writing to terminate enrollment for me and/or my dependent(s) in the vision care plan.

Signature _____ ***Date:*** _____

STAFF USE ONLY

Effective enrollment date: _____