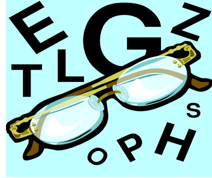

VISION SERVICE PLAN **(VSP)**

MEMBERSHIP ENROLLMENT FORM
COUNTY OF UNION, NJ
2019

(Please print or type)

1

SOCIAL SECURITY NO.	EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR
EFFECTIVE DATE	DEPARTMENT			UNION AFFILIATION

2

Please indicate which coverage level you wish to select. Under Chapter 78 Health Benefit Reforms, you must pay a percentage of the single base plan. Below are the additional contributions if you wish to add dependents:

	Contribution	**Add'l. Employee**
☐	Employee Only	-0-
☐	Employee Plus Spouse	$1.86 per pay period
☐	Employee Plus Child	$1.97 per pay period
☐	Employee Plus Children	$1.97 per pay period
☐	Employee Plus Family	$5.08 per pay period

3

PLEASE RETURN THIS FORM TO YOUR PERSONNEL OFFICE

NAMES OF DEPENDENTS TO BE COVERED (Including Spouse)	**DATE OF BIRTH**
____	_____/_____/_____
____	_____/_____/_____
____	_____/_____/_____
____	_____/_____/_____
____	_____/_____/_____

______ I wish to decline Vision Coverage at this time.

EMPLOYEE SIGNATURE: ______________________________________ **DATE**: ________________