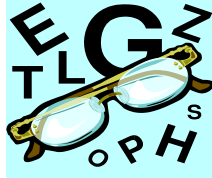

VISION SERVICE PLAN **(VSP)**

MEMBERSHIP ENROLLMENT FORM
COUNTY OF UNION, NJ
2020

(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. Dependent
☐	Employee Only	-0-
☐	Employee Plus Spouse	$1.86 per pay period
☐	Employee Plus Child(ren)	$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 **DATE OF BIRTH**

(List Spouse and Children under the age of 23)

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth
Spouse	☐ Add ☐ Remove		☐ Male ☐ Female	_____/_____/_____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	_____/_____/_____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	_____/_____/_____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	_____/_____/_____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	_____/_____/_____

Decline Coverage

______ I wish to decline Vision Coverage at this time.

EMPLOYEE SIGNATURE: ____ **DATE**: ________________