



VISION SERVICE PLAN (VSP)
MEMBERSHIP ENROLLMENT FORM
COUNTY OF UNION, NJ

(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

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:

<u>Contribution</u>	<u>Add'l. Dependent</u>
<input type="checkbox"/> Employee Only	Ch. 78
<input type="checkbox"/> Employee Plus Spouse	\$1.86 per pay period
<input type="checkbox"/> Employee Plus Child(ren)	\$1.97 per pay period
<input type="checkbox"/> Employee Plus Family	\$5.08 per pay period

3 PLEASE RETURN THIS FORM TO
YOUR PERSONNEL OFFICE

NAMES OF DEPENDENTS TO BE COVERED
(List Spouse and Children under the age of 23)

DATE OF BIRTH

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___

Decline Coverage

_____ I wish to decline Vision Coverage at this time.

EMPLOYEE SIGNATURE: _____ **DATE:** _____