**VISION SERVICE PLAN – MEMBERSHIP ENROLLMENT FORM**

RESET FORM

Name of Group **RIVERSIDE COMMUNITY COLLEGE** Department: Effective Date

| | | | |
|---|---|---|---|
| **1** | Social Security No. | Last Name / First Name / MI | Date of Birth |

| | | | |
|---|---|---|---|
| **2** | Do you have dependent children - Y ☐ N ☐<br>Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐ | **3** | Does your Spouse/Domestic Partner have ☐ coverage with VSP? If Yes, who is covered? |

**4 Coverage Level** ☐ **BASE/MATERIALS** ☐ **PREMIER PLAN**

| (√) | Rates include a $3.00 admin fee | | |
|---|---|---|---|
| ☐ | Employee Only | $ 8.04 | $ 11.42 |
| ☐ | Employee + Spouse/Domestic Partner | $13.10 | $19.83 |
| ☐ | Employee + Child(en) | $13.81 | $21.02 |
| ☐ | Employee + Family | $20.27 | $31.79 |

**PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM**

| **5** | **LAST NAME** | **FIRST NAME** | **DATE OF BIRTH** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please Return To Your Human Resources Department. Do Not Return To VSP**

**Signature**_____ **Date**_____