Employee Vision Insurance Benefits Application

Homewood-Flossmoor
Community High School District 233

Employee Information

Reason for Enrollment:

☐ New Hire ☐ Open Enrollment ☐ Special Enrollment (Qualifying Event Reason: ______________________)

☐ Termination

Effective Date ________________________________

Name (Last) ___________________________________ (First) ____________________________ (MI) ______

Mailing Address ____ Apt# _______________________

City ____ State __________________ Zip _______________

Home (or Cell) Number ______________________ Email ____

Social Security Number __________________________ Date of Birth ____________________ ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Civil Union ☐ Domestic Partner

Date of Hire _____________________ Hours/Week _______________ Location ________________________

Job Title/Occupation _____________________________

Vision Coverage — *Vision Service Plan (VSP)*

Effective date of hire (Unless Qualifying Event or Open Enrollment)

Monthly Rates	**Employee Only**	**EE & Spouse**	**EE & Child(ren)**	**EE, Spouse & Child(ren)**
Base Plan	☐ $8.44	☐ $13.50	☐ $13.78	☐ $22.21
Buy-up Plan	☐ $11.50	☐ $18.41	☐ $18.79	☐ $30.29
☐ Waive*				

*I am waiving group vision coverage for the following reason(s): (check all that apply)

☐ Spouse Employer's Plan

☐ Individual Coverage (Non-Group Plan)
☐ Cobra/State Continuation

☐ Medicare or other Government Program

☐ Other (Please Explain): ____

Dependent Enrollment Information

NOTE: In order to enroll a dependent, you must provide a photocopy of documentation to establish your dependents' eligibility. (E.g. marriage certificate for a spouse, birth certificate for children.) **Dependents will not be enrolled until proper documentation is supplied.**

SPOUSE/Name (Last) ______________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ___________________ ☐ Female

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Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

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Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

---

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

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Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

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Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____

☐ Male

Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

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I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Vision Service Plan.

Employee Signature____ Date Signed ________________