

***Vision coverage is optional and has a one-time (upon hiring) open enrollment period.
If you do not elect vision upon hiring, there will be no other opportunity to do so.**

- I decline vision coverage. I understand that there is a one-time (upon hiring) open enrollment period.
(check the box and sign below)
- I elect vision coverage. (Please complete enrollment information below)

Name: _____

Signature: _____

Date: _____

**Marin Eye Service (MES) – Classified/Confidential Staff
MEMBERSHIP ENROLLMENT FORM***

Name of Group **Larkspur-Corte Madera SD** Group # **M93-M-C-001** Effective Date _____

1	SOCIAL SECURITY #	MEMBER LAST NAME	MEMBER FIRST NAME	BIRTH DATE
2	Do you have dependent children? (Dependent children are covered through 25 years of age)		<input type="checkbox"/> Yes <input type="checkbox"/> No	3
	Are you enrolling your dependents in the VSP plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does your spouse have a vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

PLEASE LIST ALL OF YOUR ELIGIBLE DEPENDENTS

	LAST NAME	FIRST NAME	SOCIAL SECURITY #	BIRTH DATE
4	SPOUSE:			
	CHILDREN:			

PLEASE RETURN TO YOUR PAYROLL AND BENEFITS DEPARTMENT. DO NOT RETURN TO MES.