***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:** _____

VISION SERVICE PLAN (VSP) – Certificated Staff
MEMBERSHIP ENROLLMENT FORM*

Name of Group **Larkspur-Corte Madera SD** Group #**00421701-0005** Effective Date _____

1	SOCIAL SECURITY #	MEMBER LAST NAME	MEMBER FIRST NAME	BIRTH DATE

2		3	
	Do you have dependent children? ☐ Yes ☐ No (Dependent children are covered through 25 years of age) Are you enrolling your dependents in the VSP plan? ☐ Yes ☐ No		Does your spouse have a vision plan? ☐ Yes ☐ No

PLEASE LIST ALL OF YOUR ELIGIBLE DEPENDENTS

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

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

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