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 ☐ 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 ☐ **MATERIALS ONLY** ☐ **PREMIER PLAN**

(√)	Rates include a $3.00 admin fee	**RATES ARE PAID 10 TIMES A YEAR FOR 12 MONTHS COVERAGE**	
☐	Employee Only	$7.24	$ 10.09
☐	Employee + Spouse/Domestic Partner	$11.51	$17.18
☐	Employee + Child(en)	$12.11	$18.17
☐	Employee + Family	$17.54	$27.25

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**_____