



Enrollment/Change Form

Please print and complete all sections.
See instructions below.

EMPLOYER INFORMATION

| | | | |
|-------------------------|--|--------------------------|----------------|
| Group Number 9657909 | Employer Name CAJON VALLEY UNION SCHOOL DISTRICT | Location Code – Not Used | Effective Date |
|-------------------------|--|--------------------------|----------------|

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

| | | | | | | |
|---|--|----------------------|----------------------|------------|----|---------------|
| <input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Member ID - Not Used | Last Name (Employee) | First Name | MI | Date of Birth |
| Social Security # | Home Street Address | City/State/Zip | Home Phone () | | | |

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

| | | | | | | |
|--|---|-------------------------|------------|------|---------------|-------------------|
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 1 Last Name (spouse) | First Name | M.I. | Date of Birth | Social Security # |
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 2 Last Name (dependent) | First Name | M.I. | Date of Birth | Social Security # |
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 3 Last Name (dependent) | First Name | M.I. | Date of Birth | Social Security # |
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 4 Last Name (dependent) | First Name | M.I. | Date of Birth | Social Security # |
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 5 Last Name (dependent) | First Name | M.I. | Date of Birth | Social Security # |
| <input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 6 Last Name (dependent) | First Name | M.I. | Date of Birth | Social Security # |

Employee Signature: _____ Date: _____

Your Authorization: I authorize **pretax** vision plan payroll deductions for:
Employee only tenthly...\$ **9.07** **Employee + 1** tenthly. . . \$**17.13** **Employee + family** tenthly.....\$**25.11**

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date. Deductions are adjusted according to payroll frequency. I understand future rates for **48-month** renewal of this plan will be negotiated between my employer and EyeMed Vision Care.

Instructions:

Effective date: This date is set by your employer in accordance with EyeMed proposal. The employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
 Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Payroll Use Only: Effective Date _____ 30029 01 02 03 By _____