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COUNTY OF SONOMA EMPLOYEE
SCLEA, SCLEMA and SCPDIA EMPLOYEES
VISION PLAN ENROLLMENT/CHANGE FORM
FOR DEPENDENTS

☒ **I AM ELECTING VISION SERVICES PLAN (VSP) #1243-7001-0025. I UNDERSTAND THERE IS NO ADDITIONAL COST FOR ADDING DEPENDENTS AT THIS TIME.**

ENROLLEE/CHANGE INFORMATION

☒ Add/Delete Dependent ☒ Change in Status - Adoption of Successor MOU May 24, 2016

EMPLOYEE INFORMATION	**Office Use Only:**	Vision Effective Date	HR Technician Initials	Date Entered into eP

Last Name	First Name	Middle Name	FTE	Employee ID

Social Security Number	Date of Birth	Check One	Marital Status	Bargaining Unit
		☐ Male ☐ Female	☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed	

Residential Address (Required) ☐ Check Box if new address	City	State	Zip Code

Mailing Address ☐ Check Box if Same as Residential	City	State	Zip Code

Personal Email Address	Work Phone	Personal Phone	Other Phone

Check One:
☐ Employee Only
☐ Employee + 1
☐ Employee + 2 or more

ELIGIBLE DEPENDENT INFORMATION: List ALL person(s) to be covered

Last Name, First Name, MI	Action	Check One	Date of Birth	Social Security Number	Relationship	Permanently Disabled	IRS Qualified Dependent
Spouse/Domestic Partner:							
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
Children:							
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby elect the vision plan designated above on behalf of my listed eligible dependent(s). I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified.

I agree for myself and my dependent(s), effective immediately and for as long as necessary to process claims to be bound by the terms and conditions of the applicable Group Agreement as it may be amended. I understand that I must complete a new **County of Sonoma Vision Plan Enrollment/Change Form within 31 days** of a change in this qualification or a change of benefit eligibility. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

_____ _____

Employee Signature Date