COUNTY OF SONOMA EMPLOYEE
SCPA AND SCDPDAA 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 April 19, 2016

EMPLOYEE INFORMATION

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

ELIGIBLE DEPENDENT INFORMATION:

- If you are enrolling in this vision plan for the first time or changing plans, list ALL person(s) to be covered
- If you are adding or deleting dependent(s) and are not new to the plan, list only the dependents you are making enrollment changes

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 on page one 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

FOR COUNTY USE ONLY:

☐ June 1, 2016 ☐ Mid-year Start Effective Date __________ Pay Date Processed __________

Eligibility Start Date __________ Premium Start Date __________ Date Entered in eP __________ Initials __________