Santa Clara County Schools' Insurance Group

VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT

School District: **Effective Date of Enrollment:**

1. Plan Type (choose one), please be advised that your District may not have all the plans available, check with your Benefits Coordinator:

☐ Premium Group #: ☐ High Plan Group #: ☐ Low Plan Group #:

Enrollee/Change Information: ☐ New Hire ☐ Marital Status Change ☐ New Enrollment (loss of coverage) ☐ Address Change
☐ Name Change (Marriage/Divorce) ☐ Terminate Employee/Spouse/Child Coverage ☐ Other

2.

Social Security No.	**Date of Birth**	**Gender** ☐ Non-binary ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorce ☐ Separated ☐ Widowed

Employee Last name	**Employee First Name**	**Middle Initial**	**Cellphone**	**Email:** ☐ **Work** ☐ **Personal**

Address

3. Do you have dependent children? ☐ Yes ☐ No

Do your dependent children, if over age 18, attend school full time? ☐ Yes ☐ No

Are you enrolling your dependents in the Vision plan? ☐ Yes ☐ No

4. Does your spouse have a vision Plan?
☐ Yes ☐ No

If yes, who is covered?
☐ Yourself ☐ Spouse ☐ Dependent

PLEASE LIST ALL OF YOUR DEPENDENTS (IF FAMILY COVERAGE IS AVAILABLE AND SELECTED BY YOU)

Use back page of the form if you need more space for Dependent Children

5.

Last Name	**First Name**	**Middle Name**	**Social Security No.** ### - ## - ####	**Date of Birth Mo/Day/Yr**	**Relationship to Employee** (Spouse/D. Partner/Child)

Employees MUST complete their enrollment and provide proof of legal documents within 30 days of a life-changing event (ex. New Hire, loss/gain coverage, marriage, divorce, newborn/adoption addition, death, etc.). Type of Documents are Marriage Certificate, Domestic Partnership CA State Registration, Birth Certificate, and Court Document for Adoption, and Immigration Port of Entry, etc.

Employee Signature **Date**

RETURN ENROLLMENT FORM TO YOUR DISTRICT BENEFITS COORDINATOR