



Vision Service Plan Enrollment Form

Sunnyvale School District

Plan Options:

___ High Plan

___ Premium Plan

___ Low Plan

Employee Last Name

First Name

Initial

Social Security Number

Date of Birth (MM/DD/YY)

Date of Employment

Effective date of Coverage

Please list of your dependents:

Spouse:

Last Name

First Name

Initial

Gender

Date of Birth (MM/DD/YY)

Dependents:

Last Name

First Name

Initial

Gender

Date of Birth (MM/DD/YY)

Last Name

First Name

Initial

Gender

Date of Birth (MM/DD/YY)

Last Name

First Name

Initial

Gender

Date of Birth (MM/DD/YY)

The undersigned agrees to continue benefits in the program provide by the employer during employment and while the program is in force.

Signature

Date