VISION BENEFIT PLAN & ENROLLMENT FORM
ASSOCIATED STUDENTS, INCORPORATED

SUMMARY OF VISION SERVICE PLAN

Vision coverage is provided through Vision Services Plan (VSP). VSP is a preferred provider organization, which means if you seek care through their network your benefit reimbursement levels will be greater. There is a $25 deductible per year. VSP covers a standard eye examination, spectacle lenses and frames, once every 12 months. Please refer to the enclosed VSP brochure for more information.

VISION SERVICE PLAN ENROLLMENT

I wish to enroll or change my coverage in the Vision Service Plan that is provided by my employer. I understand that my coverage is provided free of charge. If I elect to cover my eligible dependents my share of the cost is $_____._____ per month and will be deducted from my paycheck on the 15th of each month. I further understand that if I decline dependent coverage I will not be eligible to add my dependent(s) until open enrollment, with the exception of a qualified change in status.

I,_____ , have read the above and select coverage as follows:

- ☐ Employee only coverage
- ☐ Waive employee coverage
- ☐ Family coverage*****
- ☐ Waive family coverage
- ☐ Add Dependent(s) due to change in status or open enrollment*****
- ☐ Waive Dependent(s) due to change in status or open enrollment*****

Qualifying event:_____

Date of qualifying event:_____

*Please list names and social security number of dependents.

Name(s)	**Social Security Number**
_____	_____
_____	_____

_____ _____

Employee Signature **Date**

Received by Human Resources:_____