Vision Service Plan
Enrollment Form

Name: _____ Date: _____

SS Number: _____ D.O.B.: _____

VSP Start Date: _____ (1st of month following eligibility)

Vision Options

(check one)

Employee ($10.18 mo.) _____

Employee + One ($16.32 mo.) _____

Employee + Children ($16.66 mo.) _____

Employee + Family ($26.84 mo.) _____

Acceptance of Coverage

By signing below, I understand that changes to my elections can not be made until a life event or open enrollment for the University. I authorize OBU to deduct premiums per payroll deduction schedule.

_____ _____

Signature Date

Declining/Cancelation of Coverage

By signing below, I am waiving the opportunity to enroll in vision insurance and understand I will not be able to enroll until next open enrollment.

_____ _____

Signature Date