COMMUNITY EYE CARE
VISION PLAN

FOR EMPLOYEES OF HALIFAX COUNTY SCHOOLS

Employee: _____ **Benefit Effective Date:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ ☐ **Male** ☐ **Female**

Date of Birth: _____

ENROLLMENT — *Please select either* ***12 Month*** or ***10 Month Plan*** (each includes an annual eye exam with $15 co-pay)

Select coverage type (below)	☐ **12 Month**	☐ **10 Month**
☐ **Employee Only**	$7.90 monthly	$ 9.48 monthly
☐ **Employee + One**	$16.25 monthly	$ 19.50 monthly
☐ **Employee + Family**	$24.92 monthly	$ 29.90 monthly

FAMILY MEMBERS *List if enrolling for* Employee + One *or* Employee + Family*)*

Name	Relationship	Date of Birth	Gender

☐ ENROLLMENT *(New Members)*

☐ CHANGE REQUESTED *(Check all that apply):* ☐ Name ☐ Address ☐ Telephone *(Enter each change in main body of form)*

☐ Add Dependent(s) *(List additions under Family Members above)*
Reason and Effective Date of Change: _____

☐ Cancel Dependent(s) *(List dependents to be cancelled under Family Members above)*
Reason and Effective Date of Change: _____

☐ TERMINATION Reason and Effective Date of Employee Termination: _____

I hereby apply for enrollment in Community Eye Care's Vision Plan. I authorize my employer to deduct the membership fees from my earnings.

_____ _____

Employee Signature *Date*