DANVILLE SCHOOL DISTRICT 118

VISION SERVICE PLAN (VSP)

DEPENDENT(s) ENROLLMENT FORM

Employee Name: _____ Building: _____

Social Security No: _____

Address: _____

_____

Date: _____

Effective Date: _____

Office Use

Group #12-001821

Div: Reg Class:1

Coverage: _____

Action: _____

I, _____ also wish to include the following dependent(s) in my Group Vision Plan. It is my understanding that I may not discontinue dependent participation during the contract year unless it is due to death or divorce. I authorize payroll deductions to continue unless I notify the Benefits Office otherwise.

Current Rate for Dependent coverage is $5.50 per pay (24 deductions).

Current Rate for Dependent coverage is $7.77 per pay (19 deductions).

	Dependent Name	Birthdate
Dependents to be enrolled:	_____	_____
	_____	_____
	_____	_____
	_____	_____

Signature: _____

PLEASE NOTE:

Dependent children are covered up to the end of the month they attain age of 26