CONTRA COSTA COUNTY
Office of Education
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VSP Eye Care Health Plan
Enrollment Form

PRINT RESET

Group Name: Contra Costa County Office of Education

A ENROLLEE (Complete this section for new enrollment or change of status)

Name

dfadfdsfsfad

Last First Middle Initial

Social Security Number

_____-_____-_____

(Member I.D. Number

Action Requested

- ○ New enrollment
- ○ COBRA enrollment
- ○ Change in enrollment
- ○ Reinstatement

Birthdate

____/____/____

Month Day Year

Sex

- ○ Male
- ○ Female

Classification

- ○ Certificated
- ○ Classified
- ○ CDC
- ○ COBRA

Mailing Address

Street number or PO box

City, State, Zip

Telephone Number

( )

☐ **COBRA Enrollment -** I understand that I will be required to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied

_____
Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date ____/____/____
Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

☐ Name Change ☐ Add new dependent ☐ Delete Dependent ☐ Address change listed above

Reason for change _____ Effective date of change ____/____/____
Month Day

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) First Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month/Day/Year	**Spouse's** Social Security #	**Marriage/Divorce Date** Month/Day/Year
			____/____/____		____/____/____

Child Name Last (if different) First Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month/Day/Year	**Child's** Social Security #

CCCOE Use Only

_____
Coverage Level

_____
Effective Date of Coverage

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to comply with the terms of the group contract.

Employee Signature _____ **Date** _____