

Retiree Enrollment Form

for the Vision Services and Employee Assistance Voluntary Plan

Participation in the Vision Services Plan and the Employee Assistance Program will be at the Retiree's own cost. Retirees who discontinue their VSP and/or EAP plan coverage after enrollment will not be allowed to re enroll.

Please complete the following: (PLEASE PRINT)

LAST NAME

FIRST NAME

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

_____/_____/_____
DATE OF BIRTH

_____-_____-_____
SOCIAL SECURITY NUMBER

FAMILY INFORMATION (PLEASE PRINT)

SPOUSE-LAST NAME

FIRST NAME

_____/_____/_____
DATE OF BIRTH

_____-_____-_____
SOCIAL SECURITY NUMBER

CHILD-LAST NAME

FIRST NAME

_____/_____/_____
DATE OF BIRTH

_____-_____-_____
SOCIAL SECURITY NUMBER

CHILD-LAST NAME

FIRST NAME

_____/_____/_____
DATE OF BIRTH

_____-_____-_____
SOCIAL SECURITY NUMBER

CHILD-LAST NAME

FIRST NAME

_____/_____/_____
DATE OF BIRTH

_____-_____-_____
SOCIAL SECURITY NUMBER

Please indicate with an (x) your interest in participating in the vision service plan. If you wish to participate please place an (x) on the coverage in which you wish to enroll.

VISION SERVICES PLAN

I **ELECT** to participate

I **DECLINE** to participate

ENROLLMENT ELECTION

SINGLE COVERAGE

TWO-PARTY COVERAGE

FAMILY COVERAGE

MONTHLY
CHARGE

\$28.53

\$41.39

\$74.20

(RATES EFFECTIVE 7/1/2019-7/1/2022)

Please indicate with an (x) your interest in participating the employee assistance program.

EMPLOYEE ASSISTANCE PROGRAM

I **ELECT** to participate

I **DECLINE** to participate

MONTHLY
CHARGE

\$11.04

SIGNATURE

DATE

PLEASE RETURN COMPLETED FORM TO:

CONTRA COSTA COMMUNITY COLLEGE DISTRICT
PAYROLL DEPARTMENT-Renita Mack phone:925-229-1000x1248
500 COURT STREET
MARTINEZ, CA. 94553