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	**ENROLLMENT ELECTION**	**MONTHLY CHARGE**
☐ I **ELECT** to participate	☐ **SINGLE COVERAGE**	**$25.39**
☐ I **DECLINE** to participate	☐ **TWO-PARTY COVERAGE**	**$36.84**
	☐ **FAMILY COVERAGE**	**$66.04**

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

EMPLOYEE ASSISTANCE PROGRAM	**MONTHLY CHARGE**
☐ I **ELECT** to participate	**$3.25**
☐ I **DECLINE** to participate	

_____ _____

SIGNATURE DATE

PLEASE RETURN COMPLETED FORM TO:

CONTRA COSTA COMMUNITY COLLEGE DISTRICT PAYROLL
DEPARTMENT-Renita Mack phone:925-229-6855
500 COURT STREET
MARTINEZ, CA. 94553