



DIVISION OF STATE GROUP INSURANCE SUPPLEMENTAL VISION INSURANCE ENROLLMENT FORM



Select Your Type of Enrollment: New Hire Qualifying Status Change Open Enrollment
* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 3.

PLEASE PRINT

Social Security Number: _____ - _____ - _____ Name: _____

Address/City/State/Zip: _____

SUNCOM: _____ Work Phone: (_____) _____ Home Phone: (_____) _____

Date of Birth: ____ / ____ / ____ Sex: _____

PART 1: SELECT ONLY ONE COVERAGE LEVEL
(Premiums listed are monthly, divide by 2 for biweekly amounts.)

Vision Plan	Company Code	Product Code	Option Code	Coverage Level	
				Employee Only (01)	Employee + Family (20)
VISIONCARE	045	107	450	<input type="checkbox"/> \$ 6.96	<input type="checkbox"/> \$ 17.88

Before you make an eye appointment you can request a Benefit Form in a number of ways: by calling the Customer Care Department at 1-800-939-5369; visiting the website at <http://www.visionhealthcare.com>; faxing to the toll-free number 1-800-421-0100; or by completing a Request postcard (see your Agency Personnel Office) and mailing it to VisionCare Plan at the address listed on the back of this form.

PART 2: EMPLOYEE CERTIFICATION

I have read the information on the back of this form and I authorize my employer to reduce my salary in accordance with the benefits I have selected. **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction, and that my elections are IRREVOCABLE, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change.**

Employee Signature: _____ Date: _____

PART 3: AGENCY CERTIFICATION

Hire Date: ____ / ____ / ____ Pay Plan: _____ SAMAS Org Code: _____

Coverage Effective Date: ____ / ____ / ____ Employment Status: _____

Agency Signature: _____ Date: ____ / ____ / ____

Check if the employee is an 8, 9 or 10 month faculty member.

Work Phone: (_____) _____ SUNCOM: _____

SUPPLEMENTAL INSURANCE INFORMATION
COMPLETION OF THE SUPPLEMENTAL OPEN ENROLLMENT FORM MEANS
THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- The Enrollment **form** must be used to enroll in or change coverages. **No changes will be accepted by phone, e-mail or letter.**
- Review your current benefits and the available plans and options.
- If making no changes to your supplemental insurance, **DO NOT** return this form to your Agency Personnel Office.
- Enrolling in a supplemental insurance plan, or changing options, does not automatically stop other coverages you currently have. To **stop an existing coverage** you must place an "S" in the space provided for that coverage on the Supplemental Enrollment Form.
- The Supplemental Enrollment Form **must** be submitted to your Agency Personnel Office. **Enrollment changes will not occur if forms and/or applications are submitted directly to the supplemental insurance company.**
- If you cancel or do not enroll in supplemental insurance, **you will not be able to enroll again until the next annual open enrollment period, unless you experience a qualifying status change.**
- Vision premiums are automatically deducted on a pretax basis.
- It is your responsibility to ensure that your Enrollment selections are in effect. **Check your payroll warrants to ensure that your deductions properly reflect your selections.** Contact your Agency Personnel Office immediately if these deductions are not correct.
- **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction, and that my elections are IRREVOCABLE, until the next open enrollment period, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change.**
- VisionCare Plan will send you a personalized benefit form that outlines your benefits, along with a list of network doctors for your area. Select a doctor of your choice from the list and schedule your appointment.
- Please give your completed and signed enrollment form to your Agency Personnel Office. **DO NOT SIGN THE SUPPLEMENTAL ENROLLMENT FORM UNLESS YOU HAVE A CLEAR UNDERSTANDING OF THE OPTIONS YOU SELECTED.** The telephone numbers for the Supplemental Insurance Companies are shown in the Supplemental Brochures and in the Benefits Guide.

VISIONCARE
PLAN

P.O. Box 30349 TAMPA, FL 33630-3349
800-939-5369
<http://www.visionhealthcare.com>

DSGI
WE'VE GOT YOU COVERED