

VISION SERVICE PLAN
City of Newport News Retiree Enrollment

SSN _____ DATE OF BIRTH _____

NAME (LAST, FIRST, MI) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Type of Coverage/Monthly Premium:

____ Retiree Only (\$8.80) ____ Retiree + 1 (\$13.80) ____ Family (\$23.80)

Last Name (If Different)	First	Initial	Sex M/F	Birthdate Mo/Day/Yr
<i>spouse</i>				
2				
<i>dependent</i>				
3				
<i>dependent</i>				
4				
<i>dependent</i>				
5				
<i>dependent</i>				
6				

I AGREE TO HAVE DEDUCTIONS TAKEN OUT OF MY RETIREMENT BENEFIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD OF JULY 2009.

SIGNATURE _____ DATE _____

- If you choose the plan for yourself, complete the form and check “**Retiree Only**”.
- If you choose to cover yourself and one family member such as a spouse or dependent child, check “**Retiree +1**” and list the name of the spouse or dependent.
- If you choose to cover yourself and 2 or more family members, check “**Family**” and list all family members to be covered.
- Your unmarried dependent(s) may stay on your vision insurance through the end of the month in which he/she reaches 19 years, or 23 years if a full-time student.

NEXT OPEN ENROLLEMNT WILL BE JULY 2009