

**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>				
<b>2</b>				
<i>dependent</i>				
<b>3</b>				
<i>dependent</i>				
<b>4</b>				
<i>dependent</i>				
<b>5</b>				
<i>dependent</i>				
<b>6</b>				

**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**