CEC community eye care

Vision Plan

For Employees of Burke County Government

Employee Name: _____

Date of Birth: _____ Gender: _____ Telephone _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Coverage Type

- ☐ Employee Only $5.48 Semi-Monthly
- ☐ Employee + Spouse $10.67 Semi-Monthly
- ☐ Employee + Child(ren) $10.76 Semi-Monthly
- ☐ Employee + Family $16.40 Semi-Monthly
- ☐ I do not wish to participate in the vision plan.

Family Members (please list if enrolling for Employee + Child(ren), Spouse or Family)

Name	Relationship	Date of Birth	Gender	Add	Term
				☐	☐
				☐	☐
				☐	☐
				☐	☐

I hereby apply for enrollment in the Community Eye Care Vision Plan for a minimum of twelve (12) months (or until the beginning of the next plan year). I authorize my employer to deduct the membership fees from my earnings. I also authorize any changes or terminations listed above.

_____ _____

Employee Signature Date

FOR BENEFITS MANAGERS USE ONLY

☐ **NEW ENROLLMENT** Benefit Effective Date _____ Employee ID # _____ *(please do not use Social Security #s)*

☐ **CHANGE REQUESTED** (*Check all that apply*) ☐ Reinstate Coverage ☐ Name ☐ Address ☐ Telephone ☐ Group Plan ☐ Add/Remove Dependent(s)

Effective Date of Change _____ Reason _____

☐ TERMINATION Effective Date of Termination _____ Reason _____

Reason Descriptions: OE (Open Enrollment) QE (Qualifying Event) NLE (No Longer Employed) RT (Retired) LOA (Leave of Absence) DE (Deceased)