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

☐ I **ELECT** to participate
☐ I **DECLINE** to participate

ENROLLMENT ELECTION	**MONTHLY CHARGE**
☐ **SINGLE COVERAGE**	**$25.39**
☐ **TWO-PARTY COVERAGE**	**$36.84**
☐ **FAMILY COVERAGE**	**$66.04**

(RATES EFFECTIVE 7/1/2019-7/1/2022)

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

EMPLOYEE ASSISTANCE PROGRAM — **MONTHLY CHARGE** **$11.04**

☐ I **ELECT** to participate
☐ I **DECLINE** to participate

_____	_____
SIGNATURE	DATE

PLEASE RETURN COMPLETED FORM TO:

CONTRA COSTA COMMUNITY COLLEGE DISTRICT
PAYROLL DEPARTMENT-Renita Mack phone:925-229-1000x1248
500 COURT STREET
MARTINEZ, CA. 94553