Vision Plan Selection Form

CUESTA COLLEGE INSURANCE/BENEFITS - 2024 VISION OPEN ENROLLMENT PLAN SELECTION FORM

Please designate your selection by checking the box next to your choice and initialing on the line next to the box.

_____	_____	_____	_____
Print Your Name Clearly	*Signature*	*Banner ID/ Last 4 of SSN*	*Date*

Voluntary Coverage Plan Year 1/1/2023-12/31/2023	**Single**	**2-Party**	**Family**	**Check Selection and Initial**
VSP - Vision Insurance	**$11.37**	**$18.48**	**$29.30**	
One eye exam every 12 months	☐	☐	☐	**Initial Here _____**
$200 Annual Maximum for Lens/Frames/Contacts every 12 months	*If adding a spouse/domestic partner or child(ren) a Change Form is required. Copies of Marriage Certificate/Domestic Partnership paperwork and 2021 Tax Return or Birth Certificates are required for coverage.*			
Zero Co-pay, Zero deductible				
☐ **Currently enrolled in VSP coverage but opting out of 2024 coverage.**				**Initial Here _____**
☐ **I would like to keep my current plan/eligible dependents.**				**Initial Here _____**
☐ **Not currently enrolled and I do not wish to enroll for 2024 coverage.**				**Initial Here _____**