Vision Care Enrollment / Waiver Form

Employee Name: ____

Employee SSN: ____

Employee Birth Date: ____

Street Address: ____

City: _________________________State: ______Zip: __________________

Waiver

I have been given an opportunity to enroll in the VSP vision program offered by Muskingum University, and I am declining enrollment at this time. I understand that I may not change this election except upon a qualified life event or during open enrollment each December. This waiver will renew automatically unless I complete a new form.

Plan Enrollment

I wish to enroll in VSP plan and with the coverage choice indicated below. I understand that the pricing indicated below is for the current year. I understand that the University will adjust my premiums based on changes in the monthly premiums as needed each year. I understand that I may not change this election except upon a qualified life event or during open enrollment each December. This plan enrollment will renew automatically unless I complete a new form.

	Option 1 **Base Plan**	**Option 2** **12/12/24**	**Option 3** **12/12/12**
Single Coverage	$ 1.84	$ 10.91	$ 16.05
Family Coverage	$ 4.15	$ 24.69	$ 36.25

______________________________________ ____________________

Employee Signature Date