

PSEA VOLUNTARY ENROLLMENT VISION PROGRAM

VSP	Plan	В	
VSP	Plan	C	П

For Office Use Only			
Effective Date			
Group No			
Contract Type			

Child Born / / Sex Child Born / / Sex	Last Name				First Name	<u> </u>				MI_	
PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF Spouse Born /	Address				City _				_ State	Zip	
Spouse	Date of Birth_		Male	Female	Phone ()		SSN:		-	
Child Born / / Sex Child Born / / / Sex Child		PLEASE	LIST ELIG	BLE DEPE	NDENTS TO	BE COVER	ED IN ADD	ITION 1	TO YOUR	SELF	
Child Born / / Sex	Spouse						_ Born _	/	_/	Sex	
Child Born / / Sex understand that I will be required to pay for these benefits. I agree to continue membership in this program for a minimum of 12 months and comply with the terms of the group contract Signature of Applicant: Date / /	Child						_ Born _	/	_/	Sex	
understand that I will be required to pay for these benefits. I agree to continue membership in this program for a minimum of 12 months and comply with the terms of the group contract Signature of Applicant: Date/	Child						_ Born _	/		Sex	
Date	Child						_ Born _	/	_/	Sex	
/ISA / MC #	I understand that	I will be required	to pay for these be	nefits. I agree to co	ontinue membership ir	this program for a	a minimum of 12 r	nonths and co	omply with the te	erms of the gro	oup contract.
f you have not yet retired: Expected Retirement Date/ Home Email	Signature of App	plicant:							Date	e/	/
• • •	VISA / MC # _					3 dig	git sec		Exp. Dat	re/_	
Please return to PSEA, Suite 240, 1390 Willow Pass Rd, Concord, CA 94520	If you have not	t yet retired: Ex	pected Retireme	ent Date		Home Ema	il				
		Р	lease return	to PSEA, S	uite 240, 139) Willow Pa	ss Rd, Con	cord, CA	94520		



PACIFIC SERVICE EMPLOYEES ASSOCIATION



VSP Vision RATE SHEET for Retiree & Associate Members of PSEA

RATES: Plan B (Low option)		2023 QUARTERLY PRICING
Member only		\$ 48.00
Member + 1 Dependent		\$ 81.00
Member + 2 or more Dependents		\$ 120.00

RATES: Plan C (High option)		2023 QUARTERLY PRICING
Member only		\$ 57.00
Member + 1 Dependent		\$102.00
Member + 2 or more Dependents		\$153.00

^{**}Please note: VSP Vision coverage is to be paid quarterly. Please remit the first quarter payment, credit card or check made payable to "**PSEA**", along with your enrollment application.