vsp vision care

PSEA
VOLUNTARY ENROLLMENT VISION PROGRAM

VSP Plan B ☐
VSP Plan C ☐

For Office Use Only
Effective Date _____
Group No. _____
Contract Type _____

PLEASE PRINT

Your Full Name _____
Last First Middle

Street Address _____ City _____ State & Zip _____

Date of Birth___/___/___ Male☐ Female☐ Phone (____)_____ SSN:_____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Spouse _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____

I 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 ____/____/____

VISA / MC # _____ 3 digit sec _____ Exp. Date ____/____/____

If you have not yet retired: Expected Retirement Date ____/____/____ Home email address_____

Please return to PSEA, Suite 240, 1390 Willow Pass Rd, Concord, CA 94520

PACIFIC SERVICE EMPLOYEES ASSOCIATION

VSP Vision RATE SHEET
for Retiree & Associate Members of PSEA

RATES: Plan B (Low option)	2026 QUARTERLY PRICING
Member only	$ 48.00
Member + 1 Dependent	$ 81.00
Member + 2 or more Dependents	$ 120.00

RATES: Plan C (High option)	2026 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.*