



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)		2027 QUARTERLY PRICING
Member only		\$ 51.00
Member + 1 Dependent		\$ 87.00
Member + 2 or more Dependents		\$ 123.00

RATES: Plan C (High option)		2027 QUARTERLY PRICING
Member only		\$ 63.00
Member + 1 Dependent		\$105.00
Member + 2 or more Dependents		\$159.00

****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.