Santa Barbara County Superior Court

VISION SERVICE PLAN ENROLLMENT FORM

Employee/Retiree's Name: _____

Employee/Retiree's ID #: _____

Employee/Retiree's Date of Birth : _____

Cost per pay period

Employee only:	$3.02
Employee + one:	$4.26
Employee + family:	$7.46

Are you covering dependents (circle one)? ☐ Yes ☐ No

If yes, list name and relationship of each:

Dependent Name	Date of birth MM / DD / YY	Relationship (spouse/child)

Frequency of Services **Copay**

Exam: Every 12 months

Lenses: Every 24* months } $10.00

Frames: Every 24 months

* If the prescription for new lenses differs from the most recent by an axis change of 20 degrees or a .50 diopter sphere or cylinder change and the new prescription improves visual acuity by at least one line on the standard eye chart, lenses will be replaced at a 12 month frequency.

Coverage should begin on the first day of _____, _____
Month Year

_____ _____

Signed Date