

Vision Plan Application
State of Wisconsin Retiree/Annuitant



Section I

Applicant Information			
Name (Last, First, MI)			Birth Date (MM/DD/YY)
Address	City	State	ZIP

Section II

Reason for Submitting Application (Check the appropriate reason)	
<input type="checkbox"/>	Initial Retiree/Annuitant Enrollment (Complete all Sections)
<input type="checkbox"/>	Change of Name or Address (Complete Sections I and V only)
<input type="checkbox"/>	Adding a Dependent [Complete all Sections, listing in Section IV the dependent(s) being added]
<input type="checkbox"/>	Marriage ____ (date)
<input type="checkbox"/>	Birth ____ (date)
<input type="checkbox"/>	Adoption ____ (date)
<input type="checkbox"/>	Other ____ (date)
<input type="checkbox"/>	Deleting Dependent(s)
<input type="checkbox"/>	Death ____ (date)
<input type="checkbox"/>	Divorce ____ (date)
<input type="checkbox"/>	Dependent reached age limit ____ (date)
<input type="checkbox"/>	Other ____ (date)
<input type="checkbox"/>	Canceling Coverage (Complete Sections I and V only)
*Note: Cancellation is effective at the end of the year in which the cancellation form is submitted	
<input type="checkbox"/>	Termination ____ (date)
<input type="checkbox"/>	Other _____ (date)

Section III

Coverage Desired	Monthly Rates
<input type="checkbox"/> Retiree/Applicant Only	\$6.38
<input type="checkbox"/> Retiree/Applicant + Spouse	\$12.76
<input type="checkbox"/> Retiree/Applicant + Child(ren)	\$12.76
<input type="checkbox"/> Retiree/Applicant + Family	\$14.98

Section IV

Complete the following information ONLY for individuals covered by the policy				
Last Name	First Name	Birth Date (mm/dd/yy)	Gender	Relationship
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

Section V

Date, Sign and Submit this form to the Department of Employee Trust Funds (ETF)	
By signing below, I agree that all information is true. I understand that I am enrolling in a voluntary plan and that VSP will automatically deduct the entire monthly vision premiums from my annuity (if available). I agree to continue enrollment in the vision plan through December 31 of the current calendar year. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.	
Date (mm/dd/yy)	Signature

For Office Use Only

ETF Member ID (9 digits)	Hire Date	Location	Coverage/Change Effective Date	Date Received	Received By	Group #
	N/A	N/A				30015309

Please mail completed form to: **VSP Client Admin Services, MS 422 PO BOX 997100, Sacramento CA 95899**
or fax to VSP at **916-463-9031**