



# ACERA Vision Plan Enrollment Form

Alameda County Employees' Retirement Association  
475 14<sup>th</sup> Street, Suite 1000  
Oakland, CA 94612  
510-628-3000 or 1-800-838-1932, Press 1

[www.acera.org](http://www.acera.org)

Please print or type

- Check the reason for completing this form:**
- Retirement                       Qualifying Event  
 Open Enrollment                 COBRA

### FOR ACERA USE ONLY

Input by: _____	Date: _____	Verified by: _____	Date: _____
Group Number: _____		Effective Date: _____	

### MEMBER ENROLLMENT INFORMATION

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Telephone No.: \_\_\_\_\_

### TYPE OF CHANGE REQUESTED

- New Enrollment                      **Circle coverage type**              Self Coverage              Self + 1 Coverage\*              Family Coverage\*
- Change Coverage                      **Circle coverage type**              Self Coverage              Self + 1 Coverage\*              Family Coverage\*
- Cancel Dependent Coverage

\* If you are adding, dropping, or changing dependent coverage, complete the Dependent Enrollment Information section below.

### DEPENDENT ENROLLMENT INFORMATION

- List all eligible dependents to be covered by the Vision Plan. Attach an additional form, if adding more than three dependents.
- To enroll a dependent child between age 19 and 24, you must also submit an *ACERA Verification of Enrollment Status Form*.

Name	Social Security No.	Relationship	Male	Female	Date of Birth	Enroll	Cancel
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

- I am **declining** dependent vision coverage. I understand that if I do not enroll my eligible dependents at this time or if I choose to discontinue coverage at a later date, there may be no provisions to re-enroll during future ACERA Open Enrollment periods.

### MEMBER AUTHORIZATION AND SIGNATURE

- ALL RETIRED ACERA MEMBERS ARE AUTOMATICALLY ENROLLED IN A VISION PLAN. COVERAGE FOR NON-ACERA MEMBERS (I.E. SPOUSE, DOMESTIC PARTNER, DEPENDENT) IS VOLUNTARY AND PREMIUM COSTS WILL BE DEDUCTED FROM THE RETIREMENT ALLOWANCE.
- I AGREE TO HAVE MY RETIREMENT ALLOWANCE REDUCED BY THE AMOUNT NEEDED TO PAY MY COST AND/OR MY SPOUSE'S/DOMESTIC PARTNER'S/DEPENDENT'S PREMIUM COST(S) FOR THE VISION PLAN, AS INDICATED ABOVE. I ALSO AUTHORIZE THE PLAN OR CARE PROVIDER TO RELEASE ANY OR ALL MEDICAL INFORMATION FOR MYSELF OR COVERED FAMILY MEMBERS WHEN INFORMATION IS NEEDED TO PROCESS VISION PLAN CLAIMS.
- I UNDERSTAND THAT THE ACERA BOARD OF RETIREMENT RESERVES THE RIGHT TO MODIFY AND/OR CANCEL MEMBER VISION COVERAGE. I UNDERSTAND THAT THE BENEFITS OF THE PLAN I CHOOSE ARE COORDINATED WITH THOSE PROVIDED UNDER ANY OTHER GROUP HOSPITAL, MEDICAL BENEFIT, OR VISION PLAN.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR A GREATER PORTION OF MY COSTS WHEN I USE A NON-PARTICIPATING PROVIDER FOR VISION SERVICE PLAN.**
- I ELECT TO BE COVERED UNDER THE OPTION I HAVE CHECKED ABOVE. I UNDERSTAND THAT MY ELECTION MAY ONLY BE REVOKED IN WRITING. I HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## ACERA Vision Enrollment Form Instructions

Please review the current *ACERA Enrollment and Health Plan Brochure* for details about your vision plan coverage.

On the next page, you will find the ACERA Vision Enrollment Form. If you would like to make changes to your vision coverage, complete and submit this Enrollment Form to ACERA by the 10<sup>th</sup> of the month in order to have coverage effective the following month. If you are making changes during Open Enrollment, be sure to return your form(s) to ACERA by December 1. Mail your form to:

ACERA  
475 14<sup>th</sup> Street, Suite 1000  
Oakland, CA 94612  
Attn: Retired Benefits Unit

### **HERE ARE INSTRUCTIONS FOR COMPLETING THIS FORM:**

#### **MEMBER ENROLLMENT INFORMATION**

- Fill out your name, Social Security number, and demographic information. This information is necessary to enroll you in the plan.

#### **TYPE OF CHANGE REQUESTED**

- Check the box indicating the type of vision plan change you are requesting. If this is a new enrollment or a change in vision plan coverage (adding or dropping dependents), indicate by circling coverage type (i.e. Self, Self + 1, or Family if enrolling more than 1 dependent).

#### **DEPENDENT ENROLLMENT INFORMATION**

- List the name, Social Security number, relationship, and birth date for all dependents you are either adding or dropping. Additionally, check the box to indicate if you are enrolling or canceling coverage for that dependent.
- If you are enrolling in the plan but are declining dependent vision coverage at this time, please check the decline/cancel box.

#### **MEMBER AUTHORIZATION AND SIGNATURE**

- Carefully read each bullet point.
- Sign and date the form.
- Keep the yellow copy for your records.
- Mail the white copy to ACERA.

**Turn the page to make changes ►**