



# 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  
Fax: 510-268-9574 [www.acera.org](http://www.acera.org)

**Check the reason for completing this form:**

- Retirement       Loss of Coverage       Change Plans  
 Open Enrollment       COBRA      Event Date: \_\_\_\_\_

<b>ACERA USE ONLY</b> Group & Division #: _____	Effective Date: _____
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## Member Enrollment Information Please print or type

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender:  Male  Female Phone No.: \_\_\_\_\_

## Type of Change Requested

**Enroll/Change Plan:** *Select ONE plan:*  VSP Choice (Standard)  VSP Premium (Buy-Up)  
*AND select ONE coverage type:*  Self Coverage  Self + 1 \*  Family Coverage\*

In enrolling/changing plans above I am:  Adding Dependent Coverage  Canceling Dependent Coverage

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

## Dependent Enrollment Information List all eligible dependents. Attach additional forms if necessary.

- To enroll a dependent child age 19 to age 26, you must submit an *ACERA Affidavit of Dependent Eligibility* form, which can be found on ACERA's website at [www.acera.org](http://www.acera.org)
- If adding dependents, submit the necessary documentation such as marriage certificate, birth certificate, etc.

Name	Social Security No.	Relationship	Male	Female	Date of Birth	Add	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

- I understand it is unlawful to knowingly (1.) provide false information to receive, reduce, or deny any benefit to myself or any person and (2.) accept and/or retain payment from a retirement system that the recipient is not entitled to. \* See note on instruction page
- I agree to have my retirement allowance reduced by the amount needed to pay my cost, if applicable, 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 Retiree Enrollment Guide* for details about your vision plan coverage.

On the opposite page, you will find the ACERA Vision Enrollment Form. If you would like to enroll or 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 November 30. Mail your form to:

**ACERA**  
**Attn: Call Center**  
**475 14<sup>th</sup> Street, Suite 1000**  
**Oakland, CA 94612**

**Note:** The County Employees' Retirement Law of 1937, as amended, provides that it is unlawful to make or cause to be made, or present any knowingly false material statement or material misrepresentation, to knowingly fail to disclose a material fact, or otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit to any person. As well, it is unlawful to knowingly accept or obtain payment from a retirement system with knowledge that the recipient is not entitled to the payment and to retain the payment for personal use or benefit.

## Member Enrollment Information

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

## Type of Change Requested (Open Enrollment or Qualifying Event)

- If you are enrolling in new coverage or changing coverage, select one plan and one coverage type.
- Check the "Adding Dependent Coverage" box if you want to add an eligible dependent to your vision coverage.
- Check the "Canceling Dependent Coverage" box if you want to cancel your dependent's vision coverage.

## Dependent Enrollment Information

- Review the section titled, "Enrolling Your Eligible Dependents" in the *ACERA Retiree Enrollment Guide* for the definition of a dependent and the requirements for adding, canceling, or retaining a dependent to/from your coverage.
- List the name, Social Security number, relationship, and date of birth for each dependent. Additionally, check the box to indicate if you are adding or canceling coverage for that dependent.
- If your dependent is age 19 to age 26, complete and attach an *ACERA Affidavit of Dependent Eligibility* form, which can be found on ACERA's website at [www.acera.org](http://www.acera.org). This is an annual requirement during Open Enrollment.
- Attach supporting documents, if your dependent is disabled.
- If you are enrolling in the vision plan but are declining dependent vision coverage at this time, please check the "I am declining dependent vision coverage" box.

## Member Authorization and Signature

- Carefully read each bullet point.
- **Sign and date the form.**
  - *If a Durable Power of Attorney (POA) or Legal Guardian/Conservatorship helped complete this form, then he/she must sign it and attach a copy of the applicable court order or POA document establishing authority to act on your behalf, if not already on file with ACERA*
- Keep a copy of the form for your records.
- Mail the completed form to ACERA.

Turn the page to make changes ►