Vision Plan Enrollment Form

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Oakland, CA 94612

If you retired with 10 or more years of ACERA service credit or with a service-connected disability retirement with any amount of service credit, you must complete and submit this form or ACERA will enroll you by default in the VSP Choice (Standard) plan. If you retired with less than 10 years of ACERA credit, you may voluntarily submit this form in order to enroll in a plan.

SECTION 1

Member Information

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

Physical Home Address

City | State | ZIP

Birth Date (mm/dd/yyyy) | Gender: ☐ Male ☐ Female ☐ Unknown

Personal Email Address | Phone

SECTION 2

Reason for Enrollment Form

Choose one:

☐ Enroll in Vision Coverage

☐ Change Vision Coverage

☐ Add or Drop Vision Coverage for Dependent

☐ Cancel Coverage ______________________________
Last Day of Coverage Requested

SECTION 3

Enrollment Event

Choose one:

☐ Open Enrollment

☐ Retirement (enter date below)

☐ Moved Out of Service Area (enter date below)

☐ Loss of Coverage (enter date below)

☐ Life Event Change (marriage/divorce/death/other) (enter date below)

Retirement, Moving, Loss of Coverage, or Family Change Date: ______________________

SECTION 4

Level of Coverage

Choose one:

☐ Self Coverage

☐ Self+1 Coverage

☐ Family Coverage

SECTION 5

Select Your Vision Plan

Review the ACERA Retiree Enrollment Guide for plan details: www.acera.org/guide.
Review plan costs here: www.acera.org/vision.

☐ VSP Choice (Standard)

☐ VSP Premium (Buy-Up)

SECTION 6

Dependent Information

- If you're adding a Domestic Partner, you must also submit an Affidavit of Domestic Partnership: www.acera.org/adp
- You must submit an Affidavit of Dependent Eligibility if enrolling a dependent other than your spouse or domestic partner who is:
  - » Ages 19-25
  - » Age 26 and older if incapable of supporting themselves due to a mental or physical disability incurred prior to age 26.
    www.acera.org/ade

Name	Last 4 of SSN	Birth Date	Relationship	Gender*
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U

*M=Male, F=Female, U=Unknown

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name)	Social Security Number

SECTION 8

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 myspouse'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.

Please keep a copy for your records

Member Signature	Date (mm/dd/yyyy)

For ACERA Use Only

Group No.: **12110712** Division No.: Effective Date: