Vision Plan Enrollment Form

Employee Name (Last, First, Middle Initial) NYSUT ID# or Employee ID#

Home Address City State Zip

Date of Birth Home Phone Email ❒ Male ❒ Female

If you are electing family coverage, list below the names of spouse/domestic partner and children, children under 26 years of age are eligible for benefits.

Add	Delete	First Name, MI Last Name (if different)	Relationship	Gender	Date of Birth
			❒ Spouse ❒ Daughter ❒ Son		
			❒ Spouse ❒ Daughter ❒ Son		
			❒ Spouse ❒ Daughter ❒ Son		
			❒ Spouse ❒ Daughter ❒ Son		
			❒ Spouse ❒ Daughter ❒ Son		

IRS Section 125 - Vision Care Election Form and Compensation Reduction Agreement

Plan Year: **July 1** through: **June 30**

*The School District and I hereby agree that my salary will be reduced, on a **pre-tax** basis, by the amount set forth below for each PAY PERIOD during the plan year (or during such portion of the year as remains after the date of this agreement). I elect to receive the following coverage under the Cafeteria Plan:*

NYSUT Vision Insurance Plan

Please Indicate Coverage Type: _____ **Individual** **$129.84 annually** _____ **Family** **$346.08 annually** ___ **Cancel Coverage**

Terms and Conditions

With regard to my salary reduction agreement and my election of benefits, I understand that the above premium will be deducted **pre-tax** based on the number of pay periods I have for the plan year.

I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next **(Open Enrollment Date)**, unless that change or revocation is on account of and consistant with a change in my family status (i.e., my marriage or divorce, death of my spouse or dependent, birth or adoption of my child, commencement or termination of employment of my spouse, my or my spouse's unpaid leave of absence or change from full-time to part-time employment {or vice versa}, a significant change in my or my spouse's health coverage attributable to my or my spouse's employment, and such other events as the Plan administrator determines will permit a change or revocation of an election.

My election of salary reduction and benefits will remain in effect until I sign a rejection of coverage form during a future open enrollment period. Failure to sign a rejection of coverage form during the election period prior to each subsequent Plan Year will be considered an election to continue to participate in the Plan for that Plan Year.

Signature **Date**