CEC
community eye care

Vision Plan

For Employees of Yadkin County Government

Employee Name: _____

Date of Birth: _____ Gender: _____ Telephone _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Coverage Type	☐ $120 Plan		☐ $175 Plan	
☐ Employee Only	$5.97	Monthly	$9.92	Monthly
☐ Employee + One	$11.75	Monthly	$19.84	Monthly
☐ Employee + Family	$17.91	Monthly	$29.76	Monthly

☐ I do not wish to participate in the vision plan.

Family Members (please list if enrolling for Employee + Child(ren), Spouse or Family)

Name	**Relationship**	**Date of Birth**	**Gender**	**Add**	**Term**
				☐	☐
				☐	☐
				☐	☐
				☐	☐

I hereby apply for enrollment in the Community Eye Care Vision Plan for a minimum of twelve (12) months (or until the beginning of the next plan year). I authorize my employer to deduct the membership fees from my earnings. I also authorize any changes or terminations listed above.

_____ _____

Employee Signature Date

FOR BENEFITS MANAGERS USE ONLY

☐ **NEW ENROLLMENT** Benefit Effective Date _____ Employee ID # _____ *(please do not use Social Security #s)*

☐ **CHANGE REQUESTED** *(Check all that apply)* ☐ Reinstate Coverage ☐Name ☐ Address ☐ Telephone ☐Group Plan ☐ Add/Remove Dependent(s)

Effective Date of Change _____ Reason _____

☐ TERMINATION Effective Date of Termination _____ Reason _____

Reason Descriptions: OE (Open Enrollment) QE (Qualifying Event) NLE (No Longer Employed) RT (Retired) LOA (Leave of Absence) DE (Deceased)