COLUMBIA FALLS SCHOOL DISTRICT
VOLUNTARY VISION PLAN ENROLLMENT FORM
Please return this form to the Business Office

Employee Name: _____ Effective Date: _____
last name, first name, middle initial

Health Plan ID Number: _____ Date of Birth: _____
(leave blank if not yet assigned)

Type of coverage selected (monthly premium $19.19)**:**

_____ Employee only

_____ Employee and Dependents (please list names of all dependents to be covered)
A dependent is any one of the following persons:

- legal spouse of the enrollee
- a child of the enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the enrollee, or other child for whom a court or administrative agency holds the enrollee responsible. A child may be covered up to age 26. An unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability and primarily dependent upon the enrollee for support and maintenance.

Spouse Name: _____ Date of Birth: _____

Child Name: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Employees and dependents electing the coverage must remain on the plan the entire enrollment period.

Application is made for benefits under the Columbia Falls School District #6 voluntary vision plan for which I am eligible. I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the plan. By signing the acceptance below I authorize Columbia Falls School District to deduct the required premium from my salary or wages on a pre-tax basis.

_____ _____
Employee Signature Date

DECLINATION OF PARTICIPATION
I have been given the opportunity to participate in the voluntary vision plan and have elected not to participate for this benefit year.

_____ _____
Employee Signature Date