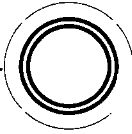
VISION INSURANCE COST

26 Pay Periods

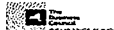
Tier	Cost
Single	$4.52
Emp. & Spouse	$9.74
Emp. & Child	$7.89
Family	$13.12

22 Pay Periods

Tier	Cost
Single	$5.35
Emp. & Spouse	$11.51
Emp. & Child	$9.33
Family	$15.50



ENROLLMENT FORM



Group No.

Vision Enrollment Form

Social Security #	Employer: **CAPCO, Inc.**							
Employee Name: First, Middle) (Last,	Date of Birth			Gender	Date of Hire			
	Month	Day	Year	= M = F	Month	Day	Year	
Employee Mailing Address Zip Code								

If enrolling for coverage, please complete this section

I am enrolling for vison coverage as indicated:

Network Selection
○ VSP-Focus Plan ○ EyeMed - ViewPointe Plan

Cover Tier Selection ○ Employee Only ○ Employee/Child(ren) ○ Employee/Spouse ○ Family

Employee Statement - Enrolling for Coverage

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation; (b) I must be regularly working on a full-time basis at my employer's business establishment or at some other location to which my employer's business requires me to travel, and (c) I have completed any applicable waiting period

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required.

Employee Signature Date Employer Representative Date

Dependent Information

Effective Relationship	Name of Eligible Dependents to be Covered		Date of Birth