Name of Group  **CONTACT COMMUNICATIONS, INC 2018** Effective Date

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | Social Security No. | Last Name / First Name / MI | | | | Date of Birth |
| 2 | Do you have dependent children - Y 🞏 N 🞏  Are you enrolling your dependents in the VSP Plan - Y 🞏 N 🞏 | | 3 | Does your spouse have coverage with VSP? 🞏  If Yes, who is covered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 4 Coverage Level and Rates | | | | | | |
| (**√**) |  | | Monthly Rates | | | |
|  |  | | Plan | | Your Cost | |
|  | Employee Only | | $12.34 | | $5.00 | |
|  | Employee + Spouse | | $19.75 | | $12.41 | |
|  | Employee + Child(en) | | $20.16 | | $12.82 | |
|  | Employee + Family | | $32.51 | | $25.17 | |
| PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM | | | | | | |
| 5 | Last Name / First Name / MI | | Social Security No. | | | Date of Birth |
|  | |  | | |  |
|  | |  | | |  |
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|  | |  | | |  |
| Please Return To Kathy Paskevich. Do Not Return To VSP | | | | | | |

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_