Sacramento City Unified School District

Vision Change Form
Certificated Non-Management Vision Option

Please complete this form to make changes in your vision coverage. Please fax this document to the Employee Benefits Office at (916) 399-2071 or send via School Mail to Box 840B. Select desired coverage and return form along with required documentation by no later than the last day of Open Enrollment, with coverage change effective November 1.

To: Employee Benefits Staff **Fax:** (916) 399-2071

Dept: Employee Benefits **Date:**

Re: Certificated Vision Option **Pages:** 1

PRINT Employee Name _____ Date of Birth _____ Employee Social Security _____

	Employee Only	Family Coverage
Examination	Every 12 months	Every 12 months
Deductible	No deductible	$15.00
Lenses	Every 12 months, only if needed	Every 24 months, only if needed
Frames	Every 12 months, only if needed	Every 24 months, only if needed
1st pair of glasses	Deductible $0.00	Deductible $15.00
2nd pair of glasses	$20.00	N/A
Contact Lenses	$50.00	Deductible $15.00 (Instead of frames and lenses)

Employee Only Coverage _____ **Family Coverage _____

****To add eligible dependents must complete dependent information below and supply required documentation (marriage/domestic partner certificate, birth certificates/adoption papers).**

Print Name	SSN#	Date of Birth	M/F	Relationship

_____ _____
Signature Date