VISION SERVICE PLAN ENROLLMENT FORM

(PLEASE PRINT)

Name: _____

Address:_____

_____

Social Security #: _____ Date of Birth (month/day/year):_____

Daytime Phone#: _____ E-mail Address:_____

Are you covering dependents? Yes _____ No_____

(Adult children eligible to age 26-employee must enroll to cover any dependents.)

If yes, list name, gender, date of birth and relationship of each below:

Dependent Name	Gender M/F	Date of birth MM / DD / YY	Relationship (spouse/child)
(add separate sheet for add'l dependents)			

Frequency of Services		**Copay**		**Monthly Rates*:**
Exam:	Every 12 months	$10 - Exam	You Only:	$ 9.78
Lenses:	Every 24 months	$10 - Materials	You + 1:	$15.94
Frames:	Every 24 months		Family:	$22.40

*If you are not a CAPE Union or Blue Shield Member, you will be charged an add'l $3.00 per month administration fee.

ARE YOU CURRENTLY AN ACTIVE LA COUNTY EMPLOYEE: YES_____ NO_____

	DEDUCTION AGENCY NAME	DEDUCTION CODE
	CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES	EU105

EMPLOYEE NUMBER	DEPT. NO.	EMPLOYEE LAST NAME	FIRST NAME	MI

DO NOT FILL IN THE SHADED AREA — **NOT TO BE USED FOR COUNTY INSURANCE PLANS**

CHANGE INDIC.	DEDUCTION AMOUNT OLD	DEDUCTION AMOUNT NEW	DEDUCT % OLD	DEDUCT % NEW
NEW				
REPL.				
CANC.				

STOP DATE	LIMIT AMOUNT		

PAYROLL DEDUCTION AUTHORIZATION

I HEREBY AUTHORIZE THE AUDITOR OF THE COUNTY OF LOS ANGELES OR HIS AGENTS TO DEDUCT MONTHLY FROM SALARY EARNED BY ME IN ANY DEPARTMENT OR DISTRICT OF THE COUNTY OF LOS ANGELES, THE AMOUNT SHOWN HEREON AND TO PAY SAME TO:

CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES

IF ALL OR ANY PORTION OF THIS DEDUCTION AUTHORIZATION INCLUDES INSURANCE PREMIUMS AND/OR EMPLOYEE ORGANIZATION DUES, I ALSO AUTHORIZE THE AUDITOR TO ADJUST FROM TIME-TO-TIME THE AMOUNT OF THIS DEDUCTION AS MAY BE REQUIRED TO COMPLY WITH ADJUSTMENTS IN COUNTY SUBSIDY AMOUNTS OR IN PREMIUMS UNDER EXISTING CONTRACTS WITH SAID INSURANCE PLANS, OR TO COMPLY WITH DUES SCHEDULES DETERMINED BY SAID EMPLOYEE ORGANIZATIONS' GOVERNING BODY IN ACCORDANCE WITH SUCH ORGANIZATIONS' CONSTITUTION CHARTER, BYLAWS, OR OTHER APPLICABLE LEGAL REQUIREMENTS.

THIS AUTHORIZATION CANCELS AND REPLACES ANY PREVIOUSLY SIGNED BY ME WITH THIS DEDUCTION AGENCY FOR THIS PURPOSE AND SHALL REMAIN IN EFFECT UNTIL CANCELLED BY ME BY WRITTEN NOTICE. I EXPRESSLY UNDERSTAND AND AGREE THAT THE AUDITOR, HIS AGENTS, OR THE COUNTY ACTING UNDER THIS AUTHORIZATION SHALL NOT BE LIABLE IN ANY MANNER FOR FAILURE OR DELAY IN MAKING THE DEDUCTIONS OR PAYMENTS HERE AUTHORIZED.

_____ _____

SIGNATURE **DATE**

You must stay enrolled for 12 months, or as long as you are a county employee, whichever is less.

YOU CAN MAIL, FAX, OR E-MAIL THIS APPLICATION TO:

Mail to: Dexheimer-Erickson Corporation
350 S. Figueroa St., Ste. 950
Los Angeles, CA 90071

FAX to: (213) 225-5611

E-Mail to: d-e.clientservices@dex-erickson.com