



A KERN COUNTY VISION PLAN FOR RETIRED EMPLOYEES

Clear Form

MEMBER INFORMATION (Please Print)

EFFECTIVE DATE: _____

Last Name		First Name	Date of Birth	Gender ☐ Male ☐ Female
Home Address			Social Security No.	
City/State/Zip Code		Telephone		Marital Status

LIST DEPENDENTS TO BE ENROLLED (IF ADDING DEPENDENT(S) SUPPORTING DOCUMENTATION WILL BE REQUIRED)

Spouse Last Name	Spouse First Name	Date of Birth	Social Security No.	Gender ☐ M ☐ F
Dep Last Name	Dep First Name	Date of Birth	Social Security No.	Gender ☐ M ☐ F
Dep Last Name	Dep First Name	Date of Birth	Social Security No.	Gender ☐ M ☐ F
Dep Last Name	Dep First Name	Date of Birth	Social Security No.	Gender ☐ M ☐ F

INITIAL

I have read and understand the eligibility policy and certify that any dependents listed on this form are eligible. If I have eligible dependents, but have not enrolled them by listing them on this form, I waive my right to request enrollment for such dependents until the next open enrollment or within 30 days of a permitting event.

INITIAL

I understand that if I choose to dis-enroll, I will not be eligible until the next open enrollment period. I agree, that if I, or my dependents, seek services when not eligible for coverage, that I will pay the vision's usual fee.

INITIAL

I understand that no dependent is permitted to continue coverage in this plan if I, as the retiree, cancel my participation.

INITIAL

I hereby authorize Kern County Health & Wellness and KCERA to make the necessary payroll deduction from my pension check to pay for vision coverage for myself and my covered dependents. I authorize Kern County Health & Wellness, KCERA and my County department to release information to each other as necessary to process this request for retiree coverage.

Retiree/Beneficiary Signature _____ Date: _____

RETURN COMPLETED FORMS TO:



1115 Truxtun Avenue, 1st Flr
Bakersfield, California 93301