Redwood Empire School's Insurance Group

Vision Plan Enrollment Form

Please complete all applicable fields to avoid any delay in your enrollment. Print or type in black or dark blue ink only. Return enrollment form to Redwood Empire School's Insurance Group (RESIG).

THIS SECTION FOR OFFICE USE ONLY:

District ______________________________ **Effective Date** ______________________________

Group Name ______________________________ **Account Number** ______________________________

☐**Add** ☐**Delete** **Name of Employee**: ______________________________

SSN: ______________________ Date of Birth: ____________________ Gender: ☐ M ☐ F

Address: ____ City: ____________________

State: __________ Zip Code: ______________ Phone #: ____________________

All dependent(s) to be enrolled in VSP: Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage may be enrolled as part of your COBRA/Retirement account. (Attach additional sheet, if needed.)

	Name	Dependent(s)	Gender	Date of Birth	SSN
☐Add ☐Delete	______________________	☐Spouse	☐ M ☐ F	__________	______________
☐Add ☐Delete	______________________	☐Child	☐ M ☐ F	__________	______________
☐Add ☐Delete	______________________	☐Child	☐ M ☐ F	__________	______________
☐Add ☐Delete	______________________	☐Child	☐ M ☐ F	__________	______________
☐Add ☐Delete	______________________	☐Child	☐ M ☐ F	__________	______________

I have read and understood the provision outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files.

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the Vision plan documents, including the Evidence of Coverage. Payment is due by the 1st of each coverage month and your coverage will be terminated if premium is not received by the last day of the coverage month.

Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, RESIG, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Enrollee Signature: ________________________________ **Date:** ____________

Mail completed form to: RESIG, 5670 Skylane Blvd., Ste. #100, Windsor, CA 95492

For questions call: RESIG (707) 836-0779, Elizabeth ext. 120 or Angela ext. 129 Revised 8/2015