

VOLUNTARY VISION PLAN FOR ACT MEMBERS APPLICATION FORM

NAME _____ SEX: F _____ M _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER (_____) DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

SCHOOL _____

ACT MEMBER STATUS: PERM. TEACHER _____ LTS* _____ RETIRED ACT MEMBER _____

* Only Long Term Subs hired prior to November 1, 2011 for the full 2011-2012 school year may participate in the Voluntary Vision Plan

PLAN SELECTION

PAYMENT OPTIONS FOR 2010-2011

Individual _____	1 payment of \$79.32 _____ DUE BY 11/25/11
2 Person _____	1 payment of \$158.88 _____ DUE BY 11/25/11 or
	2 payments of \$79.44 _____ DUE BY 11/25/11 _____ & 01/20/12
Family _____	1 payment of \$238.32 _____ DUE BY 11/25/11 or
	3 payments of \$79.44 _____ DUE BY 11/25/11, 01/20/12 & 02/17/12.

Dependent Coverage Information (Complete for all eligible dependents including spouse enrolled for coverage.) PLEASE PRINT.

<u>Spouse/Dependent Name</u>	<u>Date of Birth</u>	<u>Social Security#</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEMBER'S AGREEMENT: I understand that by electing the Voluntary Vision Plan for the benefit period January 1, 2012 through December 31, 2012 and by signing this form, I am obligated to remain in the plan and to make all payments in accordance with the payment option indicated above.

Signature: _____

Date: _____

*Members failing to make payments on time will automatically be dropped from the plan and will not be reinstated. They will also not be able to apply for the Vision Plan again.

MAKE CHECKS PAYABLE TO THE ASSOCIATION OF CATHOLIC TEACHERS