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, 2016 for the full 2016-2017 school year may participate in the Voluntary Vision Plan

PLAN SELECTION		PAYMENT OPTIONS FOR 2016-2017
Individual	_____	1 payment of $84.00____ DUE BY 11/28/2016
2 Person	_____	1 payment of $168.24____DUE BY 11/28/2016 or
		2 payments of $84.12____DUE BY 11/28/2016___ & 01/06/17
Family	_____	1 payment of $252.36____DUE BY 11/28/2016 or
		3 payments of $84.12____DUE BY 11/28/2016, 01/06/17 & 02/17/17.

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

Spouse/Dependent Name	*Date of Birth*	*Social Security#*

MEMBER'S AGREEMENT: I understand that by electing the Voluntary Vision Plan for the **benefit period January 1, 2017 through December 31, 2017** 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
1700 Sansom Street - Suite 903, Philadelphia, PA 19103