

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, 2026 for the full 2026-2027 school year may participate in the Voluntary Vision Plan.**

PLAN SELECTION	PAYMENT OPTIONS FOR 2026-2027
Individual ____	1 payment of \$124.50 due by 11/20/26
2 Person ____	1 payment of \$249.00 due by 11/20/26 or
____	2 payments of \$124.50 due by 11/20/2026 & 01/8/2027
Family ____	1 payment of \$373.44 due by 11/20/2026 or
____	3 payments of \$124.48 due by 11/20/26, 1/8/27 & 2/19/27

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

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

IF YOU ARE CURRENTLY ON THE VISION PLAN, YOU DO NOT NEED TO LIST YOUR SSN.

MEMBER'S AGREEMENT: I understand that by electing the Voluntary Vision Plan for the benefit period January 1, 2027 through December 31, 2027 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
3070 Bristol Pike, Suite 2-101, Bensalem, PA 19020**