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, 2017 for the full 2017-2018 school year may participate in the Voluntary Vision Plan.**

PLAN SELECTION		**PAYMENT OPTIONS FOR 2017-2018**
Individual	____	1 payment of $87.36 due by12/01/2017
2 Person	____	1 payment of $174.96 due by 12/01/2017 **or**
		2 payments of $87.48 due by 12/01/2017 & 01/05/2018.
Family	____	1 payment of $262.44 due by 12/01/2017 **or**
	____	3 payments of $87.48 due by 12/1/17, 1/5/18, & 2/16/18

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, 2018 through December 31, 2018 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