

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, 2019 for the full 2019-2020 school year may participate in the Voluntary Vision Plan.**

PLAN SELECTION	PAYMENT OPTIONS FOR 2019-2020
Individual _____	1 payment of \$94.44 due by 12/09/2019
2 Person _____	1 payment of \$189.24 due by 12/09/2019 or
_____	2 payments of \$94.62 due by 12/09/2019 & 01/03/2020
Family _____	1 payment of \$283.80 due by 12/09/2019 or
_____	3 payments of \$94.60 due by 12/09/19, 1/03/20, & 2/14/20

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, 2020 through December 31, 2020 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, Bldg. 2, Ste. 101, Bensalem, PA 19020**