

**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, 2023 for the full 2023-2024 school year may participate in the Voluntary Vision Plan.**

<b>PLAN SELECTION</b>	<b>PAYMENT OPTIONS FOR 2023-2024</b>
Individual _____	1 payment of \$110.40 due by 12/1/2023
2 Person _____	1 payment of \$221.40 due by 12/1/2023 <b>or</b>
_____	2 payments of \$110.70 due by 12/1/2023 & 1/12/2024
Family _____	1 payment of \$332.04 due by 12/1/2023 <b>or</b>
_____	3 payments of \$110.68 due by 12/1/23, 1/12/24 & 2/23/24

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

<b>Spouse/Dependent Name</b>	<b>Date of Birth</b>	<b>Social Security#</b>
<u>(If you are currently on the plan, you do not have to provide your Social Security #)</u>		
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEMBER'S AGREEMENT:** I understand that by electing the Voluntary Vision Plan for the benefit period January 1, 2024 through December 31, 2024 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**