EMORY ☐ Check here if your address has changed

RETIREE VISION PLAN ELECTION FORM

RETIREE INFORMATION

Name (Last, First, MI.)	Last Four Digits of Social Security Number	PeopleSoft ID (HR Use Only)
Street Address		**City/State/Zip**
Home Phone	**Alternate Contact Number**	**E-mail**

BENEFIT INFORMATION

VISION PLAN (EyeMed Vision Care Plan)

- ☐ **I select the EyeMed Vision Care Plan**
- ☐ **I decline vision coverage**

VISION PLAN COVERAGE LEVEL

- ☐ **Retiree Only**
- ☐ **Retiree/Spouse**
- ☐ **Retiree & Children**
- ☐ **Family**

VISION PLAN PREMIUM (Annual Premium is due at time of enrollment). McGriff ACH Form must be completed to make payment. Check here if you already have an ACH set up: ☐

- ☐ **Retiree Only: $147.36**
- ☐ **Retiree/Spouse: $279.36**
- ☐ **Retiree & Children: $294.00**
- ☐ **Family: $432.96**

PERSONAL INFORMATION

	Last Name	First Name	MI.	Date of Birth MM / DD / YY	Sex	Relationship	Last 4 digits of Social Security #	Vision *(please mark box)*
Retiree:					M ☐ F ☐	Self		☐ Yes ☐ No
Spouse:					M ☐ F ☐			☐ Yes ☐ No
Child(ren):					M ☐ F ☐			☐ Yes ☐ No
					M ☐ F ☐			☐ Yes ☐ No
					M ☐ F ☐			☐ Yes ☐ No

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

I understand that this election is made for the entire calendar year and that no changes can be made to add or drop coverage mid-year. I further understand that I will be able to add dependents or cancel coverage only during the Retiree Annual Enrollment Period. This authorization shall remain valid for the term of this coverage. Typed name will suffice for a signature.

Signature/
Typed Name: Date:

(HR Use Only)

Accepted by: _____ HR Data Entry Init.: _____ Date: _____

Emory University and Emory Healthcare retirees, send completed form and McGriff ACH Draft Form to: McGriff-Emory, P.O. Box 896881, Charlotte, NC 28289-6881
OR email to: Lauren.Rice@McGriff.com