VSP Vision Care Enrollment Form

Merced County Employees' Retirement Association

Sign up for VSP.

ENROLLEE INFORMATION

Social Security Number _____-_____-_____

Date of Birth _____/_____/_____

Legal First Name _____

Legal Last Name _____

Home Address _____

City _____ State _____ ZIP Code _____

Email Address _____

Phone Number _____

YOUR VSP COVERAGE (CHOOSE ONE.)

Maximum Age Limits: Child Age: **26**. Student Age: **26** Dependent would be eligible until the last day of their birth month at the age listed above.

☐ Retiree only	$10.80 Monthly
☐ Retiree + 1	$21.10 Monthly
☐ Retiree + family	$24.71 Monthly

Open Enrollment
10/19/26 - 10/30/26

Effective Date
01/01/2027

VSP Client Number
30018587

Questions?
Call VSP® at **800.400.4569**.

Enrolling in VSP is easy

Simply complete this enrollment form and mail to the address below:

VSP Attn: Individual Billing
MS 229
PO Box 997100
Sacramento, CA 95899

ADD	FAMILY MEMBER NAME (Only list dependents if you didn't select Member only)	DATE OF BIRTH (Month/Day/Year)	GENDER (M/F)	RELATIONSHIP TO RETIREE (Spouse/Domestic Partner, Child, etc.)
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☐				
☐				
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Please read before signing. By accepting the enrollment terms, I agree that all information is true and accurate. I understand that I am enrolling in this voluntary plan as described in the benefit document for a minimum twelve (12) month period. I understand that upon completion of my twelve (12) months, I will not be eligible to make changes to my plan until the next open enrollment period. I understand my VSP plan will automatically renew unless I specifically elect not to renew.
I understand that my VSP premiums will automatically be deducted from my retirement check. Uncollected premiums will result in the termination of my VSP benefit unless other payment arrangements are made with VSP.

Enrollee Signature _____ Date _____

Benefits Effective Date: 01/01/2027