SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email health@scptac.org | www.scptac.org

Vision Benefit Enrollment Form

NOTICE: All eligible participants interested in obtaining vision coverage are required to return a completed *Vision Benefit Enrollment Form* to the Fund Office via mail, fax or email at the address above.

Your vision coverage will be effective the beginning of the month following the date when your completed *Vision Benefit Enrollment Form* is received.

If you do not return a completed *Vision Benefit Enrollment Form*, you will not have vision coverage.

SECTION 1—PARTICIPANT INFORMATION

Participant Name (First, Middle Initial, Last)

Participant Social Security Number (Only last 4 required)
or Medical ID Number (T-number)

Address

City, State, ZIP Code

Date of Birth

Phone Number

Email Address

(You must use a U.S. address to qualify for VSP.)

SECTION 2—VISION BENEFIT ELECTION

☐ I elect the **VSP CHOICE** benefit for myself and eligible dependents.

SECTION 3—PARTICIPANT AGREEMENT AND SIGNATURE

I have read and understand the material provided describing my vision benefit. I have asked any questions to the Southern California Pipe Trades Administrative Corporation or Vision Service Plan (VSP) and have received acceptable answers.

I understand that if I do not return a completed *Vision Benefit Enrollment Form* I will not have vision coverage.

Once I submit a completed *Vision Benefit Enrollment Form*, I understand that my vision coverage will be effective at the beginning of the month following the date when my completed *Vision Benefit Enrollment Form* is received.

X
Participant Signature

Date