



Columbia College VSP – Vision Plan Enrollment Form

I wish to participate in the voluntary vision plan offered by Columbia College.

		Yes	No
Self	\$14.06		
Employee + 1	\$22.50		
Employee and Children	\$22.97		
Family	\$37.03		

**Premiums listed above are monthly amounts. Premiums will be payroll deducted semi-monthly (1/2 each pay period).

Employee Name (Please Print)

Employee Signature

Date

Address (Street, City, State, Zip)

Social Security Number

Date of Birth