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

Vision Benefit Enrollment Form

OPEN ENROLLMENT DEADLINE: March 31, 2020

NOTICE: All eligible participants interested in purchasing vision coverage must return a completed *Vision Benefit Enrollment Form* to the Fund Office via mail, fax or email at the address above by March 31, 2020.

Once enrolled, you may not terminate vision coverage until the next open enrollment period.

If you do not return a completed *Vision Benefit Enrollment Form* by March 31, 2020, you and your spouse will not be permitted to enroll until the next open enrollment period.

PART 1—PARTICIPANT INFORMATION

Pensioner (or Surviving Spouse) Name (First, Middle Initial, Last)

Pensioner (or Surviving Spouse) 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 provide a U.S. address to qualify for VSP.)

PART 2—VISION BENEFIT ELECTION (Check One)

I elect the following vision benefit option effective May 1, 2020:

Monthly Cost

A ☐ **NO VISION COVERAGE** — **Skip to Part 5**

B ☐ **VSP CHOICE**

Pensioner (or Surviving Spouse) only: $4.76
Pensioner & Spouse: $9.54

PART 3—VISION COVERAGE ELECTION (Check One)

I elect to cover:

A ☐ **MYSELF ONLY**

B ☐ **MYSELF AND MY ELIGIBLE SPOUSE**

(Continued on reverse…)

PART 4—ACH ELECTRONIC PAYMENT AUTHORIZATION

YOU SHOULD COMPLETE THIS PART IF YOU ARE ELECTING TO PAY FOR YOUR MEDICAL OR YOUR MEDICAL AND VISION COVERAGE THROUGH AN AUTOMATIC, MONTHLY DEDUCTION THROUGH YOUR BANK ACCOUNT. HOWEVER, IF YOU ARE ELECTING BOTH **MEDICAL AND VISION** COVERAGE AND ARE **NOT** RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND OR YOUR PENSION BENEFIT IS NOT SUFFICIENT TO COVER YOUR MEDICAL AND VISION PREMIUMS, YOU ARE **REQUIRED** TO PAY THROUGH AN ACH ELECTRONIC PAYMENT AND YOU **MUST** COMPLETE THIS PART.

By signing in Part 5 below, I authorize the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund to electronically withdraw from or deposit into my checking or savings account indicated below amounts necessary to provide vision benefits as determined by the Board of Trustees of the Fund.

Depository Name (Bank, Savings & Loan or Credit Union)

Transit/ABA/Routing Number	**Account Number**
Account Type ☐ **Checking** ☐ **Savings**	**Social Security Number** **(only last four required)**

This authorization will remain in full force and effect until the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has received, at least two weeks before the scheduled payment date, written notification from me that I want to revoke this authorization.

Account holder must verify bank account data. Please attach a voided check.

PART 5—PARTICIPANT AGREEMENT AND SIGNATURE

I have read and understand the material provided describing my vision benefit options. 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.

I understand that I will not be permitted to obtain or terminate my vision plan until the next open enrollment period, which is scheduled for late 2020, for changes effective January 1, 2021.

IF I HAVE ELECTED TO ENROLL IN VISION COVERAGE IN PART 2 OF THIS FORM AND AM NOT REQUIRED TO COMPLETE PART 4, I HEREBY AUTHORIZE THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND TO DEDUCT FROM MY MONTHLY BENEFIT PAYMENTS SUCH SUMS AS ARE PERIODICALLY ESTABLISHED BY THE TRUSTEES OF THE SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND TO PROVIDE VISION COVERAGE UNDER THAT FUND. I understand that this amount will likely increase over time. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit payment or any portion thereof, to the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund. I understand that the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has no right, enforceable against the Southern California Pipe Trades Retirement Fund, to any part of the monthly pension benefit. I understand that if this authorization is revoked, I must provide an ACH Authorization Form so that my monthly vision premiums can be deducted from my bank account. I also understand that failure to do so will result in the loss of vision coverage under the Pensioner & Surviving Spouses Health Fund. I understand that no other forms of payment will be accepted.

IF I AM NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, I HAVE COMPLETED THE ACH AUTHORIZATION IN PART 4 ABOVE.

X _____ _____

Pensioner (or Surviving Spouse) Signature Date