



Marlboro College
Election of Vision Benefits Form
2020

Name (Last, First, MI)	
Mailing Address	
Street: _____	
City, State, Zip Code: _____	
Social Security #:	Plan Year: 2020
Email:	
Election of Vision Coverage	
<input type="checkbox"/> I elect TO participate in the Vision Plan effective _____.	
Please deduct the following per bi-weekly pay period:	
<input type="checkbox"/> Employee Only	\$4.66
<input type="checkbox"/> Employee + One	\$7.46
<input type="checkbox"/> Employee + Children	\$7.61
<input type="checkbox"/> Employee, Spouse + Children	\$12.27
<input type="checkbox"/> I elect NOT to participate in the Vision Plan.	
Employee Signature	Date