FELLOWSHIP VISION ENROLLMENT FORM

(Vision coverage only available to those with medical coverage)

Vision Benefit

As a complement to Fellowship medical coverage, Purdue offers vision benefits through **VSP** - **V**ision **S**ervice **P**lan. Further information on participating providers is available at the VSP website, www.vsp.com

Coverage

You and your covered dependents will each be able to receive one eye exam every 12 months for a fee of $5.00. The vision plan also provides a discount on your frame, lenses, and contacts.

Premium Information

To receive coverage, you will need to pay the appropriate annual premium from the table below. The payment of your vision premium cannot be combined with your medical premium into a single check or credit card transaction. You will need to make a separate payment for the vision coverage. You do not have the option of making monthly payments. Premiums will not be refunded if eligibility terminates prior to the end of the plan year. Once your enrollment form is received by HR/Benefits, a billing for the premium will be sent to you by Purdue University Accounts Receivable Office. You will need to submit your annual premium to the address provided in that monthly bill.

	Student Only	**Student & Spouse**	**Student & Child(ren)**	**Student & Spouse & Child(ren)**
Annual Premium	$10	$20	$20	$30

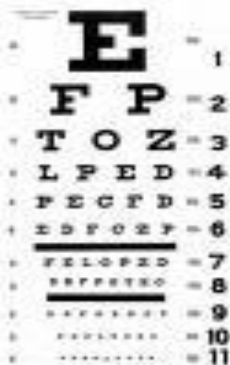
To enroll: Please provide all information, using legible **PRINT.**

FELLOW Last Name:________________________________ First Name:_____________________________________

PUID:_____________________________ **Date of Birth:** _____/_____/______

DEPENDENTS:

Name	Relationship	Date of Birth



Please return this form via fax at 765-496-1657, by email to jdmay@purdue.edu or campus mail to **Julie May, HR/Benefits, KURZ**