200 5TH AVENUE, 3RD FL, BOX 6,
WALTHAM, MA 02451

Blue Cross Blue Shield Vision
Deduction Form (2022)

Name: ____________________ Office Location: ___________________ Effective Date: 3/1/2022

DIRECTIONS: If you are choosing to participate in 42 North Dental's Vision Plan, please check off your selection from the following options, sign below, and separately complete the Blue Cross Blue Shield Vision Enrollment Form.

Single Coverage Option:

1. ___ I elect single VISION coverage, with a bi-weekly pre-tax deduction of $4.12

Family Coverage Options:

2. ___ I elect family VISION coverage, with a bi-weekly pre-tax deduction of $9.53

I understand and authorize the bi-weekly pre-tax vision deduction listed above.

________________________________ ___________________
Signature Date

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If you are choosing **not** to participate in **42 North Dental's** Vision Insurance Plan, please read and sign below.

I decline participation in the Blue Cross Blue Shield Vision Plan offered by **42 North Dental**. I understand I will **not** have the opportunity to enroll until the next Open Enrollment (March 1st of each year) or until I experience a qualifying life status event. It is my responsibility to inform **42 North Dental** of any such qualifying event immediately.

________________________________ ___________________
Signature Date