

**VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM**



Name of Group _____ Department _____ Effective Date _____

| | | | |
|----------|--|-----------------------------|--|
| 1 | Social Security No. | Last Name / First Name / MI | Date of Birth |
| 2 | Do you have dependent children - Y <input type="checkbox"/> N <input type="checkbox"/> Are you enrolling your dependents in the VSP Plan? Y <input type="checkbox"/> N <input type="checkbox"/> | | 3 |
| | | | Does your spouse have coverage with VSP? <input type="checkbox"/> If Yes, who is covered? |

4 Coverage Level and Rates

| | | |
|--------------------------|----------------------|--|
| (√) | | |
| | | |
| <input type="checkbox"/> | Employee Only | |
| <input type="checkbox"/> | Employee + Spouse | |
| <input type="checkbox"/> | Employee + Child(en) | |
| <input type="checkbox"/> | Employee + Family | |

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

| | | | |
|----------|-----------------------------|---------------------|---------------|
| 5 | Last Name / First Name / MI | Social Security No. | Date of Birth |
| | | | |
| | | | |
| | | | |
| | | | |

Please Return To Your Human Resources Department. Do Not Return To VSP

Signature _____ **Date** _____