VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT FORM

(Please Print or Type)

Name of Group ____________ Department ____________ Date of enrollment ________

1	SOCIAL SECURITY NO.	MEMBER LAST NAME	MEMBER FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR

2

Do you have dependent children? ☐ Yes ☐ No

Do your dependent children, if over age 18, attend school full time? ☐ Yes ☐ No

Are you enrolling your dependents in the VSP plan? ☐ Yes ☐ No

3

Does your spouse have a vision plan? ☐ Yes ☐ No

If yes, who is covered? ☐ Yourself ☐ Spouse ☐ Dependent

PLEASE LIST ALL OF YOUR DEPENDENTS (IF FAMILY COVERAGE IS AVAILABLE AND SELECTED BY YOU)

4	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH
	2. SPOUSE				
	3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)				

PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT. DO NOT RETURN TO VSP.

___ Confirmation of current enrollment – no changes

___ Add dependents ___ Delete dependents

___ New enrollment ___ Delete coverage __ Decline Coverage

______________________ ______________________

Signature Date