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 ☐ N ☐ Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐	3	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

(√)		
☐	Employee Only	
☐	Employee + 1	
☐	Employee + Family	
☐		

PLEASE LIST ALL OF YOUR DEPENDENTS (if employer tracks dependents)

5	**Last Name / First Name / MI**	**Date of Birth**

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

Signature________________________________ **Date**____________________