VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Group | Group number | 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

(√)			
☐	Waive Coverage		
☐	Employee Only		
☐	Employee + Spouse		
☐	Employee + Child(en)		
☐	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**	**Gender**

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

Signature_____ **Date**_____