

**VISION SERVICE PLAN  
MEMBERSHIP ENROLLMENT FORM**



Name of Group \_\_\_\_\_ Department \_\_\_\_\_ Effective Date \_\_\_\_\_

<b>1</b>	Social Security No.	Last Name / First Name / MI	Date of Birth
	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"/>		<b>3</b> Does your spouse have coverage with VSP? <input type="checkbox"/> If Yes, who is covered?

**4 Coverage Level and Rates**

(√)		Monthly Rates	
		Plan	Plan
<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**

<b>5</b>	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** \_\_\_\_\_