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 THAT WILL BE ENROLLED IN THE PROGRAM

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

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

Signature_____ **Date**_____