New_____ Update _____ Cancel_____

VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT FORM

Name of Group _____ Group # _____ Effective Date _____

1	SOCIAL SECURITY #	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)

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

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

3/99 EML447

Address _____ **City**_____ **Zip**_____

Signature_____ **Date**_____