**VSP MEMBERSHIP ENROLLMENT FORM**

![VSP logo — Vision care for life]

Name of Group _____          Department _____          Effective Date _____

| 1 | Social Security No. | Last Name , First Name  Middle initial | Date of Birth |
|---|---|---|---|

| 2 | Do you have dependent children -  Y ☐   N ☐ <br> Are you enrolling your dependents in the VSP plan? <br> Y ☐    N ☐ | 3 | Does your spouse have coverage with VSP?  ☐ <br> If Yes, who is covered? |
|---|---|---|---|

## 4 Coverage Level and Rates

| (√) | | Monthly Rates | | |
|---|---|---|---|---|
| | | Plan | Plan | Plan |
| ☐ | Employee Only | $ | $ | $ |
| ☐ | Employee + Spouse | $ | $ | $ |
| ☐ | Employee + Child(en) | $ | $ | $ |
| ☐ | Employee + Family | $ | $ | $ |

Please list all of your dependents who will be enrolled in the program

| 5 | **Last Name , First Name  Middle initial.** | **Social Security Number** | **Date of Birth** |
|---|---|---|---|
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**Please Return to your Human Resources Department.  Do Not return to VSP**

**Signature**_____ **Date**_____