VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT FORM

Please print or Type

Name of Group (Employer) North Scott Community School District Date of Employment ___________

Members Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (MO/DY/YR

- Do you have dependent children? Yes No
- Are you enrolling your dependents on the VSP Plan? Yes No
- Does your spouse have a vision plan? Yes No
- If yes, who is covered? Yourself Spouse Dependent children ___________________

I agree to remain enrolled for the entire period, assuming I remain employed. Premium rates for subsequent 12-month renewals are subject to negotiation between my employer and Vision Service Plan.

Signature ____ Date ________________________

Please list all of your dependents to be covered under the plan. If none, leave blank.

Members Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (MO/DY/YR
Spouse:				
Children: 01				
02				
03				
04				
05				
06				