

**VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM**



Name of Group _____ Department _____ Effective Date _____

1	Social Security No.	Last Name / First Name / MI	Date of Birth
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2	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"/>	3	Does your spouse have coverage with VSP? <input type="checkbox"/> If Yes, who is covered?
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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

	Last Name / First Name / MI	Social Security No.	Date of Birth
5			

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

Signature _____ **Date** _____