

VSP ENROLLMENT / CHANGE FORM

VSP FAX # (877) 654-3727
FAX DATE: _____

- ☐ Plan #30098058-1347 - Management
☐ Plan #30098058-1345 - Certificated Standard
☐ Plan #30098058-1346 - Classified Standard
☐ Plan #30098058- 1350 - Certificated Premium
☐ Plan #30098058- 1351 - Classified Premium

EFFECTIVE DATE: _____

☐ New Enrollment ☐ Change to current coverage ☐ Terminate Coverage

☐ Name Change ☐ Address Change **Hire or Change Date:** _____

☐ Add Dependents (listed below) ☐ Delete Dependents (listed below)

EMPLOYEE NAME	SOCIAL SECURITY #
ADDRESS	DATE OF BIRTH
	PHONE #
EMPLOYEE SIGNATURE _____ Date _____	WORK LOCATION
EMPLOYEE TYPE ☐ Certificated (#1345) ☐ Classified (#1346) ☐ Management (#1347)	

☐ Vision Service Plan – Employee Only ☐ Vision Service Plan – Employee + Spouse

☐ Vision Service Plan – Family ☐ Vision Service Plan- Employee+Children

☐ I do NOT wish to elect a Vision Plan. I understand by waiving my VSP plan now, I can only enroll during the next open enrollment period.

LIST OF DEPENDENTS

A = Add D = Delete	Name of Dependent	Relationship to Employee	Date of Birth	Social Security #

cc: Accounting

 Submitted by: _____
 (310) 973-1300 ext. 500 _____