VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

VSP Vision care for life

Name of Group _____ Department _____ Effective Date _____

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

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

4 Coverage Level and Rates

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

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

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

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

Signature_____ **Date**_____