

# VSP ENROLLMENT FORM

Employee name: \_\_\_\_\_  
 last name \_\_\_\_\_ first name \_\_\_\_\_ middle initial \_\_\_\_\_

Home address: \_\_\_\_\_  
 Street or P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number: \_\_\_\_\_ Marital status:  Married  
 Daytime (if different): \_\_\_\_\_  Single

Social Security number: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender:  Male  
 Female

## Complete the following if enrolling in the VSP vision plan:

Type of coverage selected:

- Employee only
- Employee + one dependent\*
- Employee + two or more dependents (family coverage)\*

\*List spouse and/or dependents (if enrolling them in your plan):

Dependent name (first, middle, last)	Birth date	Social Security #	Gender (M/F)
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Dependent name (first, middle, last)	Birth date	Social Security #	Gender (M/F)
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Dependent name (first, middle, last)	Birth date	Social Security #	Gender (M/F)
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***By completing the enrollment information above I am enrolling in the VSP vision plan.***

Employee signature	Date
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***I have been given the opportunity to enroll in the VSP plan and decline to participate.***

Employee signature	Date
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