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)

____
Dependent name (first, middle, last) Birth date Social Security # Gender (M/F)

____
Dependent name (first, middle, last) Birth date Social Security # Gender (M/F)

____
Dependent name (first, middle, last) Birth date Social Security # Gender (M/F)

☐ ***By completing the enrollment information above I am enrolling in the VSP vision plan.***

____
Employee signature Date

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

____
Employee signature Date