

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