VSP ENROLLMENT FORM

Employee name:				
last name	first name	mid	middle initial	
Home address:				
Street or P.O. Bo	X			
City	<u> </u>	State	Zip Code	
Telephone number:		Marital status	s: Married	
Daytime (if different):			Single	
Social Security number:		Date of Hire:		
Birth date:	Gender:] Male		
		Female		
Complete the following if en	rolling in the VSP	vision plan:		
Type of coverage selected:				
☐ Employee only				
Employee + one dependent	*			
Employee + two or more de		000)*		
Employee + two of more de	pendents (ranning cover	age)		
*List spouse and/or dependents (if	enrolling them in your i	olan):		
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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)	
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☐ By completing the enrollment	information above I an	enrolling in the	VSP vision plan	
Employee signature		Date		
☐ I have been given the opportur	nity to enroll in the VSI	P plan and declin	e to participate.	
Employee signature		Date		