

VSP ENROLLMENT FORM

Employee name: _____

last name	first name	middle initial
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Home address: _____
Street or P.O. Box

City	State	Zip Code
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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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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 _____