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