

**VISION SERVICE PLAN**

**MEMBERSHIP ENROLLMENT FORM**

(Please Print or Type)

Name of Group \_\_\_\_\_

Department \_\_\_\_\_ Date of enrollment \_\_\_\_\_

**1** SOCIAL SECURITY NO. \_\_\_\_\_ MEMBER LAST NAME \_\_\_\_\_ MEMBER FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MO. DAY YEAR

**2** Do you have dependent children?  Yes  No  
 Do your dependent children, if over age 18, attend school full time?  Yes  No  
 Are you enrolling your dependents in the VSP plan?  Yes  No

Does your spouse have a vision plan?  Yes  No  
 If yes, who is covered?  Yourself  Spouse  Dependent

**PLEASE LIST ALL OF YOUR DEPENDENTS (IF FAMILY COVERAGE IS AVAILABLE AND SELECTED BY YOU)**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

2. SPOUSE

3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)

4				

**PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT. DO NOT RETURN TO VSP.**

- Employee Only \_\_\_\_\_
- Employee / Spouse \_\_\_\_\_
- Employee / Child(ren) \_\_\_\_\_
- Family \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_