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

3
- 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

4	LAST NAME / FIRST NAME / M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH
	2. SPOUSE		
	3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)		

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

3/99 EML447

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