VSP

VISION ENROLLMENT FORM

Please Print: EFFECTIVE DATE: ____________________

EMPLOYEE'S NAME: ____

EMPLOYEE'S SOCIAL SECURITY #: ______________________________________

PLEASE CHECK ONE SELECTION BELOW:

☐ I would like to participate in the VSP program and the type of coverage requested is:

- ☐ Employee-Only C
- ☐ Employee Plus Spouse B
- ☐ Employee Plus Child(ren) D
- ☐ Employee Plus Family A

Relationship to Employee	Name	Social Security Number	Date of Birth	Effective Date
Employee	Self			
Spouse				
Child				
Child				
Child				
Child				

☐ I would like to drop dependent coverage (see above)

☐ I would like to cancel my VSP vision coverage

____ ____________________

Signature **Date**

PLEASE RETURN TO YOUR PAYROLL DEPARTMENT
DO NOT RETURN TO VSP