

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do your dependent children, if over age 18, attend school full time? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you enrolling your dependents in the VSP plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Does your spouse have a vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is covered? <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> 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
4	2. SPOUSE				
	3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)				

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

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