



**Vision Service Plan
Membership Enrollment Form**

Vision Service Plan Membership Enrollment Form				
Name of Group:		Group #		Date of Enrollment:
Social Security No.	Member Last Name:	Member First Name:	Date of Birth (m/d/y)	
Do you have dependent children?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Does your spouse have a vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
Do your dependent children if over the age of 18, attend school full time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you enrolling your dependents in the VSP plan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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)				
LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	
2.) Spouse				
3.) Children (include surname if different)				
Signature:		Date:		
PLEASE RETURN TO YOUR HUMAN RESOURCE DEPARTMENT. DO NOT RETURN TO VSP.				