VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Group_____ Active/Cobra_____ Effective Date_____

1	**Social Security No.**	**Last Name / First Name / MI**	**Date of Birth**
2	**Address**		**Email Address**

3	**Nature of Application:** □New Contract Application □Cancel Contract □Add/Remove Dependent: ○*Add Spouse* ○*Add Dependent Child* ○*Remove Spouse* ○*Remove Dependent Child* □Change Contract: ○*Name Change* ○*Address Change*	**4**	**Qualifying Event Type:** □New Hire Enrollment □Marriage □ Birth/Adoption □Loss of Coverage □Open Enrollment Date Event Occurred: _____

5 Coverage Level and Rates

(✓)	Please check desired level of coverage	Your Rates	
		Bi-monthly	**Monthly**
	Employee Only	**$ 3.80**	**$ 7.60**
	Employee +1 Dependent	**$ 7.60**	**$15.20**
	Employee + Family	**$12.24**	**$24.48**

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

6

Last Name / First Name / MI	Relationship	Social Security No.	Date of Birth
	Spouse		
	□Son □Daughter		
	□Son □Daughter		
	□Son □Daughter		
	□Son □Daughter		

Please Return To Your Human Resources Department. Do Not Return To VSP.

Signature_____ **Date**_____