Vision Plan Enrollment Form

INSTRUCTIONS: Please complete all of your personal and dependent information below. Select the plan and the type of coverage you wish to enroll in, sign and date the form, and return to the Department of Human Resources.

Employee Name: _____ Date of Birth: _____
Last First M.I. (mm/dd/yyyy)

Home Address: _____
City State ZIP Code

SSN: _____ Email Address: _____ Phone: _____
(no dashes)

Gender: ☐ male ☐ female Date of Hire: _____ Effective Date of Coverage: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Type of coverage selected:

Bi-Weekly Rates

	☐ Member only	☐ Member + 1	☐ Member + children	☐ Family
☐ Base Plan (Plan B)	$3.23	$ 5.16	$ 5.27	$ 8.50
☐ Premium Plan (Plan C)	$ 4.79	$ 7.67	$ 7.83	$12.62

☐ **CANCEL COVERAGE**

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

Dependent last name	Dependent first name	Gender	* Dependent Relationship	Date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	

Employee Signature: _____ Date: _____

****You will NOT receive a membership card from VSP, they use your SSN to identify you. You may print a card on the VSP website.**

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