Vision Service Plan

Member Enrollment Form

Employee Information: **Effective Date** ____________

Name ______________________________

Address ______________________________

City, St Zip ______________________________

Date of Birth ______________ **Hired Date** ______________

Social Security Number ______________

I am enrolling in the Vision Service Plan vision program and have selected the following coverage (please check one):

Employee Only
Employee and One Dependent
Employee and Family

Dependent(s) Information:

Last	First/MI	Relationship	Sex (M/F)	Birthday MM/DD/YY	Social Security Number
		Spouse			
		Child			
		Child			
		Child			
		Child			
		Child			

I certify that the information supplied by me on this form is accurate to the best of my

I have been offered the opportunity to enroll in the vision program through Vision Service Plan (VSP) and I am waiving coverage.

I authorize payroll deduction

Signature: ______________________________ Date: ____________

Note: Family status change may allow you to add or delete coverage during this period.