VSP MEMBERSHIP ENROLLMENT FORM

Name of Group _____ Department _____ Effective Date _____

1	Social Security No.	Last Name , First Name Middle initial	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP plan? Y ☐ N ☐	3	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

		Monthly Rates		
(√)		Plan	Plan	Plan
☐	Employee Only	$	$	$
☐	Employee + Spouse	$	$	$
☐	Employee + Child(en)	$	$	$
☐	Employee + Family	$	$	$

Please list all of your dependents who will be enrolled in the program

5	**Last Name , First Name Middle initial.**	**Social Security Number**	**Date of Birth**

Please Return to your Human Resources Department. Do Not return to VSP

Signature_____ **Date**_____