Vision Service Plan (VSP) Enrollment Form

Name: _____

Social Security Number: _____

Date of Birth: _____

Hire Date: _____

Gender:

- ☐ Male
- ☐ Female

Select Coverage (Please select one):

- ☐ Employee only
- ☐ Employee + Spouse
- ☐ Employee + 1 Child
- ☐ Employee + 2 or more Children
- ☐ Family [Employee + Spouse + Child(ren)]
- ☐ Decline Coverage

Spouse's name: _____ Date of Birth: _____ SSN:_____

Child's name: _____ Date of Birth: _____ SSN:_____

Child's name: _____ Date of Birth: _____ SSN:_____

Child's name: _____ Date of Birth: _____ SSN:_____

Child's name: _____ Date of Birth: _____ SSN:_____

Child's name: _____ Date of Birth: _____ SSN:_____

Signature: _____ Date: _____