VISION SERVICE PLAN ENROLLMENT/CHANGE FORM

Enrollee's Name (Last name, First Name)	Social Security No.	Gender M☐ F☐		Date of Birth
Mailing Address:	City	State	Zip	Phone

Are you covering dependents? (mark one) ☐ Yes ☐ No

Dependent Name (Last name, First name)	Date of birth MM/DD/YY	Relationship (spouse/child)

New ☐ Enrollment VSP Standard B

Change ☐ (mark one)
- ☐ Add dependent
- ☐ Cancel coverage

Cobra ☐ (mark one)
- ☐ Termination of employment
- ☐ Reduction in hours resulting in loss of coverage
- ☐ Divorce or legal separtion
- ☐ Loss of coverage due to employee Medicare entitlement
- ☐ Age limitation of a dependant being reached
- ☐ Death of employee

Coverage Effective Date: _____

_____

Employee's Signature **Date**