

## VISION SERVICE PLAN ENROLLMENT/CHANGE FORM

Enrollee's Name (Last name, First Name)	Social Security No.	M	ender F∏	Date of Birth		
Mailing Address:	City	State	Zip	Phone		
Are you covering dependents? (mark one)		Yes		No		
Dependent Name (Last name, First name)		of birth DD/YY		Relationship (spouse/child)		
New Change Enrollment VSP Standard B	(mark one) (mark one)  Add dependent Terminati  Cancel coverage Divorce of Loss of country Age limite			k one) nation of employment stion in hours resulting in loss of coverage se or legal separtion of coverage due to employee Medicare entitlement mitation of a dependant being reached of employee		
Coverage Effective Date:						
Employee's Signature	Date	<del>-</del>				