VISION SERVICE PLAN

WWW.VSP.COM

800-877-7195

- ☐ New enrollment hire date ____________ (mm/dd/yyyy) Effective Date: ____________
- ☐ Re-hire date ____________ (mm/dd/yyyy)
- ☐ Change (Marriage/Birth) COBRA Date: ____________

Section 1 - Employee information

Please Print

Social Security Number	**Employer**	**Group Number**	
Last Name	**First Name**	**Middle Initial**	
Address	**City**	**State**	**Zip**
Home phone number	**E-Mail address**		
Birthdate (mm/dd/yyyy)	**Gender** Male ☐ Female ☐	**Marital Status** Single ☐ Married ☐ Domestic Partner ☐	
Hours Worked (If less than full-time)	**Position**	**Work Site**	

Section 2- Dependent Information

Please Print

Spouse ☐ Domestic Partner ☐ Male ☐ Female ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**
Son ☐ Daughter ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**
Son ☐ Daughter ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**
Son ☐ Daughter ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**
Son ☐ Daughter ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**
Son ☐ Daughter ☐			
Last Name	**First Name**	**Date of Birth**	**Social Security**

I Agree: All informaton on this form is correct and true to the best of my knowledge and belief. I understand it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings any contribution required toward the cost of this plan.

Signature of Employee: ______________________________ Date: __________