Vision Service Plan
Membership Enrollment / Termination Form

Name of Group:	Group #	Date of Enrollment:_____ Date of Termination:_____

Social Security No.	Member Last Name:	Member First Name:	Date of Birth (m/d/y)

Do you have dependent children?	Yes ☐	No ☐	Does your spouse have a vision plan? ☐ Yes ☐ NO
Do your dependent children if over the age of 18, attend school full time?	Yes ☐	No ☐	If yes, who is covered? ☐ Yourself ☐ Spouse ☐ Dependent
Are you enrolling your dependents in the VSP plan?	Yes ☐	No ☐	

PLEASE LIST ALL OF YOUR DEPENDENTS (If Family Coverage is Available and Selected)

LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
2.) Spouse			
3.) Children (include surname if different)			

Signature:_____ Date: _____

PLEASE RETURN TO YOUR HUMAN RESOURCE DEPARTMENT. DO NOT RETURN TO VSP.