VISION SERVICE PLAN MEMBERSHIP ENROLLMENT CARD

(Please Print or Type)

Name of Group_____ Date of Employment_____

1	SOCIAL SECURITY NO. – –	LAST NAME FIRST NAME MIDDLE INITIAL _____ MEMBER	SEX M ☐ F ☐	DATE OF BIRTH MO. DAY YR.	STATUS ☐ MARRIED ☐ SINGLE

2	Do you have dependent children? Yes ☐ No ☐ Do your dependent children, if over age 19, attend school full time? ☐ Yes ☐ No Are you enrolling your dependents in the VSP Plan? ☐ Yes ☐ No	3	Does your spouse have a vision plan? ☐ Yes ☐ No If yes, who is covered? ☐ Yourself ☐ Spouse ☐ Dependent Children

4	If your employer is not paying the cost of dependent coverage do you authorize payroll deductions for this coverage? ☐ Yes ☐ No

5	The undersigned agrees to continue benefits in the program provided by the employer and while the program is in force. Date _____ Signed_____

PLEASE LIST ALL OF YOUR DEPENDENTS

LAST NAME FIRST NAME M.I. SEX DATE OF BIRTH LAST NAME FIRST NAME M.I. SEX DATE OF BIRTH

6	2. SPOUSE	M/F	MO. DAY YR	6.		
	3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)			7.		
	4.			8.		
	5.			9.		