VSP - MEMBERSHIP ENROLLMENT FORM

Name of Client: _____ VSP Client Policy ID: _____

Division/Class: ____/____ Effective Date: _____

1	Employee SSN	Last Name / First Name / MI	Email Address	Date of Birth **(YY/MM/DD)**
	Street Address:	City:	State:	Zip code:
2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Coverage? Y ☐ N ☐			
3	Coverage Level (Check one)			

(√)		
☐		Employee Only
☐		Employee + Spouse
☐		Employee + Child(ren)
☐		Employee + Family

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

4	**Surname / First Name / MI**	**Relationship** **S – Spouse** **DP - Domestic Partner** **C – Child** **T – Student** **H - Handicapped Child aka Disabled Dependent**	**Date of Birth (YY/MM/DD)**	**Student Yes/No**

Please Return To Your HR Department

Signature_____

Date_____

VSP Vision care for life