Vision Enrollment Form

Group Vision Coverage Provided by
Vision Service Plan (VSP)

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	☐ Enroll ☐ Cancel ☐ Change ☐ Waiver **EFFECTIVE DATE:** / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER HOME ( ) WORK ( )	☐ Male ☐ Single	☐ Female ☐ Married

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Employee ☐ Employee + One ☐ Family

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		☐ Wife	☐ Husband	☐ M ☐ F	☐ Student at: ________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet**.**

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE
TYPE OF COVERAGE

SIGNATURE ____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Vision Agreement