

Vision Service Plan (VSP) Enrollment/Change Form

(District name) _____ 

Effective Date _____
Employee SS# _____ **DOB** / /
Last Name _____ **First Name** _____ **MI** _____
Address _____

(Check One)
EE Only _____ **EE + One Dependent** _____ **EE + Family** _____

Dependent Information:

Add (A) Term (T)	Last Name, First Name, MI	Relationship	Sex	Full-Time Student	DOB
			M F	Y N	<u> </u> / <u> </u> / <u> </u>
			M F	Y N	<u> </u> / <u> </u> / <u> </u>
			M F	Y N	<u> </u> / <u> </u> / <u> </u>
			M F	Y N	<u> </u> / <u> </u> / <u> </u>
			M F	Y N	<u> </u> / <u> </u> / <u> </u>
			M F	Y N	<u> </u> / <u> </u> / <u> </u>

Employee Signature _____ **Date** _____

Original – Employer