

# 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 <input type="checkbox"/> N <input type="checkbox"/>			
	Are you enrolling your dependents in the VSP Coverage? Y <input type="checkbox"/> N <input type="checkbox"/>			
3	Coverage Level (Check one)			
	( <input checked="" type="checkbox"/> )			
<input type="checkbox"/>	Employee Only			
<input type="checkbox"/>	Employee + Spouse			
<input type="checkbox"/>	Employee + Child(ren)			
<input type="checkbox"/>	Employee + Family			
<b>PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM</b>				
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
<b>Please Return To Your HR Department</b>				

Signature \_\_\_\_\_

Date \_\_\_\_\_

