



VISION SERVICE PLAN - ENROLLMENT FORM

|   |                  |                          |
|---|------------------|--------------------------|
| Employee name:<br>Last name, first name, middle initial | Employee social: | Employee date of birth:  |
|   |                  |                          |
| Enrolling dependents name:                              | Relationship:    | Dependent date of birth: |
|   |                  |                          |
|   |                  |                          |
|   |                  |                          |

Type of coverage selected:

- Employee only \$9.80
- Employee + one dependent \$16.80
- Employee + children \$17.15
- Employee + family \$27.65

\_\_\_\_\_  
Employee Signature

*Please return this form to your benefits administrator.  
Do not return to VSP.*