

# VSP - MEMBERSHIP ENROLLMENT FORM

**Name of Client:** \_\_\_\_\_ **VSP Client Policy ID:** \_\_\_\_\_

**Division/Class:** \_\_\_\_\_ / \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

<b>1</b>	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)**

(√)		
<input type="checkbox"/>		Employee Only
<input type="checkbox"/>		Employee + Spouse
<input type="checkbox"/>		Employee + Child(ren)
<input type="checkbox"/>		Employee + Family

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

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

**Please Return To Your HR Department**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

