vsp vision care

Enrollment Form with Dependent Data

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected:

☐ employee only $_____
☐ employee and one dependent $_____
☐ employee and children $_____
☐ employee and family $_____
☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

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

Classification: Confidential