Vision Enrollment Form

Employee Name	EE Number	SSN
Mailing Address (PO Box or Street)		Date of Birth
City	State	Zip
Effective Date	Date of Hire	Date of Re-hire

Please Check One

- ○ New Applicant
- ○ Waive Vision Coverage
- ○ Add / Change Reason for change: _____

Please check the coverage you are applying for:

- ○ Employee Only
- ○ Employee / Spouse
- ○ Employee / Child(ren)
- ○ Family

Enrollment Information: Please Print Clearly

Relationship	**Name(First, MI, Last)**	**Gender**	**Date of Birth**	**Disabled? If Yes indicate reason**
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer. I authorize my employer, as my agent to deduct from my pay or collect from me in advance the premium therefore and remit such sums to VSP on my behalf.

Employee Signature _____ Date _____