VISION PLAN ENROLLMENT/CHANGE REQUEST

Employee Effective Date

EMPLOYEE INFORMATION

Current Last Name:	First Name:		MI:
Address:	Employee ID/SSN:		Date of Birth (mm/dd/yy)
City:	State:	Zip code:	Date of Hire:
Group Name:			VSP Group Number:

PLEASE ENROLL/ CHANGE MY PLAN AS INDICATED

☐ New Enrollee ☐Add Dependent(s) ☐ Delete Dependent(s) | If adding spouse, give marriage date:

Eligible dependents are your spouse and unmarried children within the ages stated in your evidence of coverage. Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the VSP Vision evidence of coverage.

☐ Change my name as shown. My former name is:

LIST BELOW ALL DEPENDENTS

Effective Date	Change	Relationship	Sex	First Name	MI	Last Name	Date of Birth (mm/dd/yyyy)	Full-Time Student?
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No
	☐ Enroll ☐ Add ☐ Del							☐ Yes ☐ No

SIGNATURE: ____ DATE: ________________________

PLEASE SUBMIT THIS FORM TO YOUR EMPLOYER