



**VISION SERVICE PLAN
ENROLLMENT FORM**

Name of Group (Employer) _____

Employee Name: _____
last name, first name, middle initial

Employee Social Security Number: _____

Employee Date of Birth: _____

Type of coverage selected:

____ **Employee only**

____ **Employee plus family**

____ **Waive Coverage**

Employee Signature

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