VSP Vision 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 one dependent

_____Employee plus children

_____Employee plus family

_____Waive Coverage

_____
Employee Signature

Please return this form to your benefits administrator.
Clients: This form provided for your internal use only. Please do not return to VSP. Thank you.