# VSP - MEMBERSHIP ENROLLMENT FORM

**Name of Client:** ________________ **VSP Client Policy ID:** ________

**Division/Class:** ____/____ **Effective Date:** ________

| | | | | |
|---|---|---|---|---|
| **1** | Employee SSN | Last Name / First Name / MI | Email Address | Date of Birth **(YY/MM/DD)** |
| | Street Address: | City: | State: | Zip code: |

| | |
|---|---|
| **2** | Do you have dependent children - Y ☐ N ☐<br>Are you enrolling your dependents in the VSP Coverage? Y ☐ N ☐ |
| **3** | **Coverage Level** **(Check one)** |

| (√) | | |
|---|---|---|
| ☐ | | Employee Only |
| ☐ | | Employee + Spouse |
| ☐ | | Employee + Child(ren) |
| ☐ | | Employee + Family |

**PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM**

| **4** | **Surname / First Name / MI** | **Relationship**<br>**S – Spouse**<br>**DP - Domestic Partner**<br>**C – Child**<br>**T – Student**<br>**H - Handicapped Child aka Disabled Dependent** | **Date of Birth (YY/MM/DD)** | **Student Yes/No** |
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**Please Return To Your HR Department**

**Signature**________________________________

**Date**___________