ENROLLMENT FORM

For

VSP BENEFIT

(Do not return this form to VSP)

Please Print Clearly

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

Employee Social Security Number: _____

Employee Date of Birth: _____

Type of coverage selected:

_____Employee only

_____ Employee and one dependent

_____ Employee and children

_____ Employee and family

(After signing below, please return this form to your Benefit Administrator.)

_____ _____
Employee Signature Date