SIGN UP FOR VSP COVERAGE

Employee Only: $13.28
Employee + One: $22.77
Employee + Children: $23.25
Employee + Family: $37.48

Complete the enrollment form:

SS#: _____/_____/_____

NAME: _____ _____ ____ / _____ / _____
Last ***First*** ***Date of Birth***

I wish to elect coverage for: *

Employee Only _____ ***Employee + One Dependent*** _____ ***Family*** _____
*If you are electing coverage for one dependent or family, please complete Dependent Information.

Dependent Information:

NAME: _____ _____ ___/___/____ _____
Last First Date of Birth: **S**pouse/Partner

NAME: _____ _____ ___/___/____ _____
Last First Date of Birth: **C**hild - **M/F**

NAME: _____ _____ ___/___/____ _____
Last First Date of Birth: **C**hild - **M/F**

NAME: _____ _____ ___/___/____ _____
Last First Date of Birth: **C**hild - **M/F**

NAME: _____ _____ ___/___/____ _____
Last First Date of Birth: **C**hild - **M/F**

Member Signature _____***Date:*** _____