VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Group _____ Department _____ Effective Date: 01/01/2020

1	Social Security No.	Last Name / First Name / MI	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐	**3**	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

(√)	
☐	Employee Only
☐	Employee + Spouse
☐	Employee + Child(en)
☐	Employee + Family

2020 Rates:
Actives- $6.00 per pay period
Retirees- $12.89 per month

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

5	**Last Name / First Name / MI**	**Social Security No.**	**Date of Birth**

Please Return To VCPFA. Do Not Return To VSP/FIRE HR/VCERA

Signature_____ **Date**_____