vsp vision care

Enrollment Form with Dependent Data

Employee Name (first and last): _____

Social Security Number: _____

Date of birth (mm/dd/yyyy): _____ Gender: ☐ male ☐ female ☐ other

Employee Home Address: _____

Email Address: _____

Type of coverage selected: ☐ employee only ☐ employee and one dependent ☐ employee and child(ren)
☐ employee and family ☐ waive coverage

Coverage Start Date: _____ *** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

Dependent first name	Dependent last name	* Dependent Relationship	Gender	Date of birth mm/dd/yyyy
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /
		☐S ☐C ☐H ☐T		/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

Office Use Only – Complete prior to sending to VSP

Group Name:	Client ID (8-digits):
Division Name:	Division ID (4-digits):