Enrollment Form

Name of Group (Employer) _____

Employee Name: _____

Employee Social Security # _____

Employee Date of Birth: _____

Type of coverage selected:

_____Employee only

_____Employee plus dependents

Dependent's Name _____ **DOB** _____

Name _____ **DOB** _____

Name _____ **DOB** _____

Name _____ **DOB** _____

Name _____ **DOB** _____

_____ Waive Coverage

_____
Employee Signature

Please return this form to your benefits administrator.

Clients: This form provided for your internal use only. Please do not return to VSP. Thank you.