



VISION SERVICE PLAN
ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1.

Employee Name: _____ UIN: _____

Print Last name, first name, middle initial

_____ Employee Only _____ Employee plus children

_____ Employee plus one dependent _____ Employee plus family

SECTION 4. Please list all persons to be covered by this application.

_____ / _____ / _____
1. Self (print: Last, First) Date of Birth

_____ / _____ / _____
2. Dependent Name (print: Last, First) Date of Birth

_____ / _____ / _____
3. Dependent Name (print: Last, First) Date of Birth

_____ / _____ / _____
4. Dependent Name (print: Last, First) Date of Birth

SECTION 5. Authorization -

_____ _____
Employee Signature Date

Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: _____