Enrollment Form

Name of Group (Employer) _____

Employee Name: _____
Last name, First name, Middle initial

Employee Social Security Number: _____

Employee Date of Birth: _____

☐ **New Enrollment** ☐ **Change in Enrollment**

Type of coverage selected:

_____Employee only

_____Employee plus one dependent (spouse)

_____Employee plus child

_____Employee plus family

_____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.