



VSP ENROLLMENT FORM

District Office Only
EFFECTIVE DATE

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MARK ONE BOX:

- New Enrollment
- Adding a dependent (change)
- Deleting a dependent (change)
- Decline coverage **(FACULTY ONLY)**

PLEASE PRINT

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	QUALIFIES AS IRS DEPENDENT	FULL-TIME STUDENT	DATE OF BIRTH
EMPLOYEE							
SPOUSE / DP							

ADDRESS:

TELEPHONE:

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	QUALIFIES AS IRS DEPENDENT	FULL-TIME STUDENT	DATE OF BIRTH
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
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<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							
<input type="checkbox"/> SON							
<input type="checkbox"/> DAUGHTER							

Please Select One(1) Option Below:

Vision Service Plan 10thly Deduction Rates:

Employee Only	\$12.05	<input type="checkbox"/>
Employee Plus 1 Dependent	\$23.24	<input type="checkbox"/>
Family (Employee Plus 2 or More)	\$35.06	<input type="checkbox"/>

*****MONTHLY DEDUCTION RATES APPLY TO FACULTY EMPLOYEES ONLY*****