VISION SERVICE PLAN
ENROLLMENT FORM

Last Name _____ *First Name* _____ *M.I.* _____

Employee Social Security Number _____ *Effective Date (mm/dd/yyy)* _____

Type of coverage selected: *(please check one)*

- ☐ **Employee Only**
- ☐ **Employee + Spouse**
- ☐ **Employee + Family**

Dependent Information

	Last Name, First Name, M.I.	*Relationship*	*Sex*	*Date of Birth*
1			☐ *M* ☐ *F*	
2			☐ *M* ☐ *F*	
3			☐ *M* ☐ *F*	
4			☐ *M* ☐ *F*	
5			☐ *M* ☐ *F*	
6			☐ *M* ☐ *F*	