



**Vision Service Plan
Membership Enrollment Form**

Name of Group: Physician's Endoscopy	Group # :	Division:	Effective Date of Enrollment:
Center Name:			

Social Security No.	Member Last Name:	Member First Name:	Date of Birth (mm/dd/yyyy)
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Election		If yes, who is covered? <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
Employee Only	Yes <input type="checkbox"/>	
Employee + 1 Dependent	Yes <input type="checkbox"/>	
Employee + 2 or more Dependents	Yes <input type="checkbox"/>	
I elect to waive coverage	Yes <input type="checkbox"/>	

PLEASE LIST ALL OF YOUR COVERED DEPENDENTS

LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
2.) Spouse			
3.) Children (include surname if different)			FT Student? Yes <input type="checkbox"/>
			FT Student? Yes <input type="checkbox"/>
			FT Student? Yes <input type="checkbox"/>
			FT Student? Yes <input type="checkbox"/>
			FT Student? Yes <input type="checkbox"/>

Signature:	Date:
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PLEASE RETURN TO YOUR HUMAN RESOURCE DEPARTMENT. DO NOT RETURN TO VSP.