Enrollment Form

Name of Group (Employer) _____

Employee Name: _____
last name, first name, middle initial

Employee Social Security Number: _____-_____-_____

Employee Date of Birth: _____/_____/_____

Type of coverage selected:

☐ **Employee only**

☐ **Employee plus one dependent**

☐ **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.

RESET PRINT & SUBMIT