Vision care for life

ENROLLMENT FORM

Please Print EFFECTIVE DATE: _____

GROUP NAME/NUMBER_____ **Park Pro 12140666**

EMPLOYEE'S SOCIAL SECURITY #: _____

EMPLOYEE'S NAME: _____

(last name, first name, middle initial)

EMPLOYEE'S DATE OF BIRTH_____

PLEASE CHECK ONE SELECTION BELOW:

☐ I WOULD LIKE TO ENROLL IN THE VSP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:

C ☐ Employee-Only

A ☐ Employee Plus Family

☐ CHANGE OF STATUS. ENROLLMENT CHANGE SELECTION:

_____ _____

Signature Date

Please return to your Benefits Department

Do Not Return to Vision Service Plan