VSP MEMBERSHIP ENROLLMENT FORM

Name of School _____ Department **COBRA** Effective Date _____

1	Social Security No.	Last Name , First Name Middle initial	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP plan? Y ☐ N ☐	3	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

Employee Address:

_____ _____

Street City ST Zip

_____ _____

Email Address phone

Please list all of your dependents who will be enrolled in the program

5	**Last Name , First Name Middle initial.**	**Social Security Number**	**Date of Birth**

Signature_____ **Date**_____