VISION SERVICE PLAN MEMBERSHIP ENROLLMENT CARD
(Please Print or Type)

1	Social Security No - -	Last Name First Name Middle Initial _____ Member	Sex ____ M ____ F	Date of Birth Mo Day Year	Status ____ Married ____ Single

2	Do you have children? ____ Yes ____ No Do your dependent children, if over age 19, attend school full time? ____ Yes ____ No Are you enrolling your dependents in the VSP plan? ____ Yes ____ No	3	Does your spouse have a vision plan? ____ Yes ____ No If yes, who is covered? ____ Yourself ____ Spouse ____ Dependent Children

4	If your employer is not paying the cost of dependent coverage, do you authorize payroll deduction for this coverage? ____ Yes ____ No

5	The undersigned agrees to continue benefits in the program provided by the employer during employment and while the program is in force. Date _____ Signed _____

Please list all of your dependents

	Last Name First Name MI	Sex	Date of Birth		Last Name First Name MI	Sex	Date of Birth
6	2. Spouse	M/F	Mo. Day Yr.		6.	M/F	Mo. Day Yr.
	3. Children (include surname if different)				7.		
	4.				8.		
	5.				9.		