VISION SERVICE PLAN ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1. Employee Name: Print Last name, first name, middle initial ____Employee plus children ____Employee Only be covered by this application. ____ / _____ / ______ Date of Birth 1. Self(print: Last, First) Date of Birth 2. Dependent Name (print: Last, First) Date of Birth 3. Dependent Name (print: Last, First) 4. Dependent Name (print: Last, First) Date ofBirth SECTION 5. Authorization -Employee Signature Date Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: