



**SIGN UP FOR VSP COVERAGE**

Employee Only: \$8.31  
Employee + One: \$12.90  
Employee + family: \$20.47

**Complete the enrollment form:**

SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth

**I wish to elect coverage for: \***

Employee Only \_\_\_\_\_ Employee + One Dependent \_\_\_\_\_ Family \_\_\_\_\_

\*If you are electing coverage for one dependent or family, please complete Dependent Information.

**Dependent Information:**

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth: Spouse/Partner

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth: Child - M/F

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth: Child - M/F

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth: Child - M/F

NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Date of Birth: Child - M/F

**Member Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_