



Vision Care Plan (VSP) Enrollment & Changes

Employee Information

Name:	SSN:	DOB:	Gender:
Email:		Phone:	
Address:		ZIP:	
City:	State:	Date of Hire:	Hrs Worked:

To enroll in the Vision Care Program, you need to complete the application below

- NEW ENROLLMENT
- ADD DEPENDENT
- DROP DEPENDENT
- TERMINATION OF COVERAGE
- DECLINE COVERAGE**

I wish to enroll (Please check one)

- EMPLOYEE ONLY COVERAGE - BI-WEEKLY PREMIUM: \$2.88
- EMPLOYEE + ONE - BI-WEEKLY PREMIUM: \$6.06
- EMPLOYEE + FAMILY - BI-WEEKLY PREMIUM: \$9.27

Please complete this section only if enrolling or dropping dependents

Supporting documentation is required for dependents **not** already enrolled in Local Gov Health / Dental Insurance.

Name (First, Middle Initial, Last)	DOB	Sex	Drop / Add

Employee Acknowledgement and Signature:

I authorize payroll deduction for vision coverage and must remain in the program through the plan year unless there is a qualifying event.

Employee Signature	Date:
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