VSP
ENROLLMENT FORM

Please Print EFFECTIVE DATE: _____

GROUP NUMBER: 12088763 GROUP NAME : Hopi Jr./Sr. High School

EMPLOYEE'S SOCIAL SECURITY #: _____

EMPLOYEE'S NAME: _____
(last name, first name, middle initial)

EMPLOYEE'S DATE OF BIRTH_____

EMPLOYEE'S ADDRESS _____

_____

PLEASE CHECK ONE SELECTION BELOW:

☐ I WOULD LIKE TO WAIVE VISION COVERAGE FOR MYSELF/DEPENDENTS

☐ I WOULD LIKE TO ENROLL IN THE VSP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:

- ☐ Employee-Only
- ☐ Employee Plus Family

☐ CHANGE OF STATUS. ENROLLMENT CHANGE SELECTION:

DEPENDENTS TO BE ADDED/DELETED

Spouse ☐ Add ☐ Delete _____ Date of Birth: _____

Child ☐ Add ☐ Delete _____ Date of Birth: _____

Child ☐ Add ☐ Delete _____ Date of Birth: _____

Child ☐ Add ☐ Delete _____ Date of Birth: _____

_____ _____
Signature Date