VSP

Vision Plan
ENROLLMENT/CHANGE FORM
NAPEBT – 12239817

☐ Add
☐ Change
☐ Cancel

EFFECTIVE DATE: _____ **EMPLOYEE'S SSN:** _____

EMPLOYEE'S NAME: _____

EMPLOYEE'S DATE OF BIRTH: _____

☐ I WOULD LIKE TO ENROLL IN THE VSP EXAM PLUS PROGRAM.

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

C ☐ EE Only
A ☐ EE+Family

PLEASE LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER:

SPOUSE: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____

_____ _____
Signature Date

Please return to your Benefits Department
<u>Do Not Return</u> to Vision Service Plan