



VISION SERVICE PLAN  
ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1.

Employee Name: \_\_\_\_\_ UIN: \_\_\_\_\_

Print Last name, first name, middle initial

\_\_\_\_\_ Employee Only                      \_\_\_\_\_ Employee plus children

\_\_\_\_\_ Employee plus one dependent    \_\_\_\_\_ Employee plus family

SECTION 4. Please list all persons to be covered by this application.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
1. Self (print: Last, First)                      Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
2. Dependent Name (print: Last, First)                      Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
3. Dependent Name (print: Last, First)                      Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
4. Dependent Name (print: Last, First)                      Date of Birth

SECTION 5. Authorization -

\_\_\_\_\_  
Employee Signature                      Date

Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: \_\_\_\_\_