VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)	Effective Date
Delaware County	

Employee Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip

Gender: ☐ Male ☐ Female	Do you have dependent children? Y ☐ N ☐ Are you enrolling your dependents in the VSP plan? Y ☐ N ☐	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

Coverage Level and Rates

☐ **Employee Only**

☐ **Employee + Spouse**

☐ **Employee + Child/Children**

☐ **Family**

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

Spouse Last Name	First Name	Middle Initial	Date of Birth	Gender
Dependent Last Name	First Name	Middle Initial	Date of Birth	Gender
Dependent Last Name	First Name	Middle Initial	Date of Birth	Gender
Dependent Last Name	First Name	Middle Initial	Date of Birth	Gender
Dependent Last Name	First Name	Middle Initial	Date of Birth	Gender
Dependent Last Name	First Name	Middle Initial	Date of Birth	Gender

Please return to your Insurance Department. Do not return to VSP.

Employee Signature:_____ Print Name:_____Date:_____