**VISION SERVICE PLAN**
**MEMBERSHIP ENROLLMENT FORM**

Name of Group **School of Visual Arts** Department _____ Effective Date _____

| | | | |
|---|---|---|---|
| **1** | Social Security No. | Last Name / First Name / MI | Date of Birth |

| | | | |
|---|---|---|---|
| **2** | Do you have dependent children - Y ☐ N ☐<br>Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐ | **3** | Does your spouse have coverage with VSP? ☐<br>If Yes, who is covered? |

## 4 Coverage Level and Rates

| (√) | | Semi -Monthly Rates |
|---|---|---|
| ☐ | Employee Only | $4.62 |
| ☐ | Employee + One | $9.24 |
| ☐ | Employee + Family | $14.87 |

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

| **5** | **Last Name / First Name / MI** | **Social Security No.** | **Date of Birth** |
|---|---|---|---|
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**Please Return To Your Human Resources Department. Do Not Return To VSP**

**Signature**_____ **Date**_____