Enrollment / Change / Cancellation Form

Employee Social Security Number: _____

Employee Name: _____

Employee Address: _____

_____

Employee Date of Birth: _____

Hire Date:_____

Effective Date: _____ 1, 20____ ____
(If new hire, the effective date cannot be prior to the hire date)

NOTE: ***You can only cancel VSP coverage after being enrolled for @ least 12 months.***

Type of Coverage Selected:

_____Employee (C) ($9.90/mo.)

_____Employee + One (spouse or child) (B) ($18.19/mo.)

_____Employee + Children (D) ($18.61/mo.)

_____Employee + Family (A) ($31.36/mo.)

_____Waive Coverage

_____Cancel Coverage (Effective end of ____/____/_____)

_____ _____
Employee Signature Date