Enrollment / Change / Cancellation Form

Employee Social Security Number: ______________________________

Employee Name: ____

Employee Address: ____

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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) ($10.32/mo.)

_____Employee + One (spouse or child) (B) ($18.90/mo.)

_____Employee + Children (D) ($19.34/mo.)

_____Employee + Family (A) ($32.54/mo.)

_____Waive Coverage

_____Cancel Coverage

_____________________________ _____________________
Employee Signature Date

Effective 10/01/22 to 09/30/24