${f V}$ ision ${f S}$ ervice ${f P}$ lan membership enrollment card New Enrollment Enrollment Change Add Dependents Drop Dependants Cancel Plan Name of Group:______ Date of Employment: _____ Social Security No. First Name M.I. **Date of Birth Last Name** Sex Status M ____ Married Single _ **Coverage Type:** Address ☐ Single ☐ 2 party ☐ Family Does your spouse have a vision plan? ____Yes ____ No Do you have dependent Children? ___ Yes ___ No If yes, who is covered? Do your dependent children, if over age 19, attend school fulltime? __Yes __No | __Yourself ___Spouse ___Dependent Children If your employer is not paying the cost of dependent coverage, do you authorize payroll deduction for the coverage? Yes No The undersigned agrees to continue benefits in the program provided by the employer during employment and while the program is in force. Signed: _____ PLEASE LIST ALL OF YOUR DEPENDENTS First Name Date of Birth Last Name First Name M.I. Date of Birth Last Name M.I. Sex Sex Spouse