

VISION SERVICE PLAN  
ENROLLMENT – CHANGE FORM – Vision Care

SECTION 1.

Employee Name: \_\_\_\_\_ UIN: \_\_\_\_\_

Print Last name, first name, middle initial

\_\_\_\_\_ Employee Only

\_\_\_\_\_ Employee plus children  
be covered by this application.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
1. Self (print: Last, First) Date of Birth

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
2. Dependent Name (print: Last, First) Date of Birth

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
3. Dependent Name (print: Last, First) Date of Birth

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
4. Dependent Name (print: Last, First) Date of Birth

SECTION 5. Authorization -

\_\_\_\_\_

Employee Signature

\_\_\_\_\_

Date

Please return this form to your Human Resources Office. Do not return to VSP.

EFFECTIVE DATE: \_\_\_\_\_