Vision care for life

Vision Service Plan
Membership Enrollment Form

Name of Group:	Group # **30026678**	Date of Enrollment:
City of Methuen		

Social Security No.	Member Last Name:	Member First Name:	Date of Birth (m/d/y)

Do you have dependent children?	Yes ☐	No ☐	Does your spouse have a vision plan? ☐ Yes ☐ NO
Do your dependent children if over the age of 18, attend school full time?	Yes ☐	No ☐	
Are you enrolling your dependents in the VSP plan?	Yes ☐	No ☐	If yes, who is covered? ☐ Yourself ☐ Spouse ☐ Dependent

PLEASE LIST ALL OF YOUR DEPENDENTS (If Family Coverage is Available and Selected)

LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
2.) Spouse			
3.) Children (include surname if different)			

Signature: Date:

PLEASE RETURN TO YOUR HUMAN RESOURCE DEPARTMENT. DO NOT RETURN TO VSP