VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

VSP Vision care for life

Name of Group Green Township Board of Education Department _____ Effective Date _____

1	Social Security No.	Last Name / First Name / MI	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐	**3**	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

(√)			
			Plan B - 12/12/24 $10/$25
☐	Employee Only		**$7.40**
☐	Employee + 1		**$11.84**
☐	Employee + Children		**$12.09**
☐	Employee + Family		**$19.49**

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

5	**Last Name / First Name / MI**	**Social Security No.**	**Date of Birth**

Please Return To Your Human Resources Department. Do Not Return To VSP

Signature_____ **Date**_____