FOR INTERNAL USE ONLY

_____ Classified _____ Certificated

_____ Management

Effective Date: _____

VSP Enrollment Form

Name: _____ Social Security: _____

Address: _____ Date of Birth: _____

City, State, Zip _____ _____ Male _____ Female

Home Phone: _____ Cell Phone: _____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED:

Name: _____ Date of Birth: _____ Gender M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Signature of Enrollee: _____ Date: _____