



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: _____ Gender M F Relationship: _____

SSN: _____

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

SSN: _____

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

SSN: _____

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

SSN: _____

Signature of Enrollee: _____

Date: _____