HWRSD
VSP – Vision Service Plan

Please complete enrollment information and return to Payroll for processing.

Employee Name _____

Street Address _____

City, State, Zip _____

Employee SSN _____

Birthdate _____

Check coverage option:

- ☐ Individual plan
- ☐ Employee plus one
- ☐ Family plan

All dependents to be covered must be listed here:

Name	Birthdate (xx/xx/xxxx)	Gender (M/F)

Plan Type	**Individual**	**EE plus one**	**Family**
Monthly Premium	$7.65	$11.09	$19.89

By signing below, I agree to monthly deductions for the premium for the VSP Plan. I also understand that this premium is paid one month in advance of the coverage month. (For example, the deductions in January pay for the February coverage month.) If I wish to cancel, I must do so in writing.

_____ _____

Signature Date

Please note that VSP does not issue enrollment cards, enrollment is verified on line at the Dr. office.