

**VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM**



Name of Policy: City of Somerville, Massachusetts
Policy # 30056138

Department Name: _____
Effective Date of coverage: _____

1	Social Security No.	Last Name / First Name / MI	Date of Birth
2	Do you have dependent children - Y <input type="checkbox"/> N <input type="checkbox"/> Are you enrolling your dependents in the VSP Plan? Y <input type="checkbox"/> N <input type="checkbox"/>		3
Does your spouse have coverage with VSP? <input type="checkbox"/> If Yes, who is covered?			

4 Coverage Level and Rates

(√)	Coverage Level Elected:	Employment Status:	VSP Plan Choice Plan B (12/12/24) Monthly Rates:
<input type="checkbox"/>	Employee Only	<input type="checkbox"/> Active Employee (0001)	\$5.18
<input type="checkbox"/>	Employee + Family	<input type="checkbox"/> Retiree (0002)	\$14.32
<input type="checkbox"/>	Decline Vision Coverage		---

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

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

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

Signature _____ **Date** _____