VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Policy: **City of Somerville, Massachusetts** **Department Name**: _____
Policy # **30056138** **Effective Date of coverage**: _____

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

(√)	Coverage Level Elected:	Employment Status:	VSP Plan Choice Plan B (12/12/24) Monthly Rates:
☐	Employee Only	☐ **Active Employee (0001)**	**$5.52**
☐	Employee + Family	☐ **Retiree (0002)**	**$15.27**
☐	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**_____