Vision Service Plan
Membership Enrollment Form

Date of Enrollment:

Name of Group: **University of South Alabama**
Group # **40150482**

Employee Phone #:

Employee J#:

Member Last Name:

Member First Name:

Social Security No.:

Date of Birth (m/d/y):

Type of coverage: ☐ Individual ☐ Family

Pay Status: ☐ Biweekly ☐ Monthly

NATURE OF THE APPLICATION – CHECK THE APPROPRIATE BOX FOR THE ACTION DESIRED

☐ New Contract Application
☐ Cancel Contract

Change Contract:
☐ Name Change/Address Change
☐ Type Coverage Change

Add/Remove Dependent:
☐ Add Spouse ☐ Remove Spouse
☐ Add Child ☐ Remove Child

Date event occurred (Example: Date of Marriage, Birth Date of Child, Date of Death, Etc.): _____

PLEASE LIST ALL OF YOUR DEPENDENTS (If Family Coverage is Available and Selected)

LAST NAME / FIRST NAME	RELATIONSHIP	SOCIAL SECURITY NO.	DATE OF BIRTH
2.) Spouse	SPOUSE ☐ Male ☐ Female		
3.) Child (include surname if different)	☐ Son ☐ Daughter		
4.) Child (include surname if different)	☐ Son ☐ Daughter		
5.) Child (include surname if different)	☐ Son ☐ Daughter		

Do your dependent children if over the age of 18, attend school full time?
☐ Yes ☐ NO

Does your spouse have a vision plan?
☐ Yes ☐ NO

If yes, who is covered?
☐ Yourself ☐ Spouse ☐ Dependent

Premiums are paid one-month in advance. Based on the date of your enrollment application, retroactive premium payments may be required to start your coverage. Further, I attest that everything in the application is true. By using an electronic signature, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Employee Signature: _____ Date: _____

PLEASE RETURN TO YOUR HUMAN RESOURCE DEPARTMENT. DO NOT RETURN TO VSP.

STOP – TO BE COMPLETED BY UNIVERSITY OF SOUTH ALABAMA HR DEPARTMENT REPRESENTATIVE

All the information appears to be complete and correct.

_____ _____
Signature of HR Representative Date

Last revised 11/2022