# VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT FORM

*(Please Print or Type)*
Name of Group _CITY OF RICHMOND_ Department ______________________ Effective Date of Enrollment 01/01/2022 Enrollment Code _______

| 1 | SOCIAL SECURITY NO. | MEMBER LAST NAME | MEMBER FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH (MM/DD/YY) |
|---|---|---|---|---|---|
| | | | | | |

**2**

Do you have dependent children? ___ Yes ___ No

Do your dependent children, if over age 18, attend school full time? ___ Yes ___ No

Are you enrolling your dependents in the VSP plan? ___ Yes ___No

**3**

Does your spouse have a vision plan? ___Yes ___No

Does your Domestic Partner have a vision plan? ___Yes ___No

If yes, who is covered? ___Yourself ___Spouse ___Dependent ___Domestic Partner

**PLEASE LIST ALL OF YOUR DEPENDENTS** (IF FAMILY COVERAGE IS AVAILABLE AND SELECTED BY YOU)

| 4 | LAST NAME | FIRST NAME | M.I. | ADD/DELETE | SOCIAL SECURITY NO. | DATE OF BIRTH |
|---|---|---|---|---|---|---|
| | 1. SPOUSE | | | | | |
| | 2. DOMESTIC PARTNER | | | | | |
| | 3. CHILDREN (INCLUDE SURNAME IF DIFFERENT) | | | | | |
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**PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT. DO NOT RETURN TO VSP.**

07/11

SIGNATURE ________________________________________________ DATE ____________________________