Vision Service Plan

Enrollment Form with Dependent Data

Name of Group (Employer): University of Southern Indiana_

Group Number: _30070811_____

Employee Last Name, First Name, MI: _____

Employee ID#: _____

Date of Birth (mm/dd/yyyy): _____

Effective Date of Coverage: _____

Type of Coverage Selected:

☐ Employee Only
☐ Employee and Spouse
☐ Employee and Children
☐ Employee and Family

☐ Waive Coverage

Add/**T**erm	Dependent Last Name	Dependent First Name	Date of Birth mm/dd/yyyy	Social Security #	Gender	Dependent Relationship **S**pouse/**C**hild
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C
☐A ☐T			/ /			☐S ☐C

Employee Signature: _____ Date:_____