Vision Service Plan — Employee Enrollment Card

PLEASE PRINT Employee's Name (Last, First, Middle Initial) ______________________

Employee's Social Security # ☐☐☐ - ☐☐ - ☐☐☐☐

Street Address ______________________

City ______ State ______ Zip ______

Sex ☐ Male ☐ Female

Date of Birth ____ / ____ / ____

Employer ______________________

Job Location ______________________

Hire Date ____ / ____ / ____

Coverage Status:

☐ Employee Only

☐ Employee & Dependent

LIST ALL DEPENDENTS TO BE COVERED BELOW

	LAST NAME (IF DIFFERENT)	FIRST	MI.	DATE OF BIRTH		
				MO	DAY	YR
1	SPOUSE					
2	CHILD					
3	CHILD					
4	CHILD					
5	CHILD					

Add others if necessary.

Form 007
5M
11/85

Signature ______________________ Date ______________________

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