VISION PLAN
ENROLLMENT & DEDUCTION AUTHORIZATION

☐ New Enrollment ☐ Add Dependent ☐ Remove Dependent

Employee Name:	Social Security Number (last 4 numbers):
Click here to enter text.	XXX-XX-Click here to enter text.

☐ Employee Only

☐ Employee +1 Dependent

☐ Employee +2 or More Dependents (Family)

I authorize deductions to be made from my salary to cover the cost of dependent enrollment as it is now or may be in the future. I also certify that the names of all dependents given to the vision provider are eligible family members as defined in the VSP Disclosure Form and Evidence of Coverage. Further, I understand that deductions will be made the second payroll of each month for coverage the following month.

______________________________ Click here to enter text.

Employee Signature Date