

**VISION SERVICE PLAN**

**MEMBERSHIP ENROLLMENT FORM**

*(Please Print or Type)*

Name of Group COUNTY OF SANTA BARBARA Department \_\_\_\_\_ Date of enrollment \_\_\_\_\_

|          |  |                  |  |                |                               |
|----------|--|------------------|--|----------------|-------------------------------|
| <b>1</b> | SOCIAL SECURITY NO.  | MEMBER LAST NAME | MEMBER FIRST NAME  | MIDDLE INITIAL | DATE OF BIRTH<br>MO. DAY YEAR |
| <b>2</b> | Do you have dependent children?                                      |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                |                               |
|          | Do your dependent children, if over age 18, attend school full time? |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                |                               |
|          | Are you enrolling your dependents in the VSP plan?                   |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                |                               |
| <b>3</b> | Does your spouse have a vision plan?                                 |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                |                               |
|          | If yes, who is covered?  |                  | <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent |                |                               |

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

|          | LAST NAME                               | FIRST NAME | M.I. | SOCIAL SECURITY NO. | DATE OF BIRTH |
|----------|---|------------|------|---------------------|---------------|
| <b>2</b> | SPOUSE                                  |            |      |                     |               |
| <b>4</b> | CHILDREN (INCLUDE SURNAME IF DIFFERENT) |            |      |                     |               |
|          |   |            |      |                     |               |
|          |   |            |      |                     |               |
|          |   |            |      |                     |               |

**PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT. DO NOT RETURN TO VSP.**