VISION SERVICE PLAN
ENROLLMENT FORM

Name of Group: City of Pacifica

Employee Name: _____
Last, First, Middle Initial

Employee Social Security Number: _____

Type of Coverage Selected:

_____ **Employee Only (Coverage Code "C")**

_____ **Employee + One Dependent (Coverage Code "B")**

_____ **Employee + Family (Coverage Code "A")**

Address: _____

City, State, Zip: _____

Date of Birth: _____

_____
Employee Signature

Please return this form to your benefits Administrator. ***Do not return to VSP.***

COVERAGE CANCELLATION

Are you cancelling coverage?	☐ **Yes**	☐ **No**
For yourself?	☐ **Yes**	☐ **No**
For your family?	☐ **Yes**	☐ **No**