

**VISION SERVICE PLAN  
MEMBERSHIP ENROLLMENT FORM**



Name of Group: Tulsa Firefighter

Client Number: 30034074

Division: Active(0001)  COBRA (0002)  Retirees (0003)

Effective Date \_\_\_\_\_

<b>1</b>	Social Security No.	Last Name / First Name / MI	Date of Birth
<b>2</b>	Do you have dependent children - Y <input type="checkbox"/> N <input type="checkbox"/> Are you enrolling your dependents in the VSP Plan? Y <input type="checkbox"/> N <input type="checkbox"/>		<b>3</b>
			Does your spouse have coverage with VSP? <input type="checkbox"/> If Yes, who is covered?

<b>4 Coverage Level and Rates</b>	
(v)	<b>Monthly Rates</b>
<input type="checkbox"/> Employee Only	\$ 6.77
<input type="checkbox"/> Employee + Family	\$19.32

<b>PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM</b>			
<b>5</b>	Last Name / First Name / MI	Social Security No.	Date of Birth

Please Return To Your Human Resources Department. Do Not Return To VSP

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_