VISION SERVICE PLAN

Open Enrollment Change Form and New Enrollment

Please return this form to your benefits administrator. Do not return to VSP

Name of Group (Employer) **CITY OF FULLERTON**

GROUP ACCOUNT NUMBER **00105100 Division 0002**

Employee Name: _____
last name, first name, middle initial

Employee Social Security Number: _____

Employee Date of Birth _____

Employee # _____ **Department #**_____

Type of coverage selected:

_____**Employee only**

_____**Employee and one dependent**

_____**Employee and family**

This coverage is effective on _____

Employees and dependents electing the VSP coverage must remain on the plan the entire contract period or until a voluntary cancel due to coverage on another health care plan.

_____ _____
Employee Signature Date