Vision Plan Application
State of Wisconsin Employee

VSP® Vision care for life

Section I

Employee/Applicant Information			
Name (Last, First, MI) ,			Birth Date (MM/DD/YY)
Address	City	State	ZIP

Section II

Reason for Submitting Application (Check the appropriate reason)

- ☐ Initial Enrollment (Complete all Sections)
- ☐ Change of Name or Address (Complete Sections I and V only)
- ☐ Adding a Dependent [Complete all Sections, listing in Section IV the dependent(s) being added]
  - ☐ Marriage _____ (date)
  - ☐ Domestic Partnership _____ (date)
  - ☐ Birth _____ (date)
  - ☐ Adoption _____ (date)
  - ☐ Other _____ (date)
- ☐ Deleting Dependent(s)
  - ☐ Death _____ (date)
  - ☐ Domestic Partnership Termination _____ (date)
  - ☐ Divorce _____ (date)
  - ☐ Dependent reached age limit _____ (date)
  - ☐ Other _____ (date)
- ☐ Canceling Coverage (Complete Sections I and V only)

  *Note: Cancellation is effective at the end of the year in which the cancellation form is submitted
  - ☐ Termination _____ (date)
  - ☐ Other _____ _____ (date)

Section III

Coverage Desired	Monthly Rates
☐ Employee/Applicant Only	$6.54
☐ Employee/Applicant + Spouse/Domestic Partner	$13.08
☐ Employee/Applicant + Child(ren)	$14.73
☐ Employee/Applicant + Family	$23.54

Section IV

Complete the following information ONLY for individuals covered by the policy

Last Name	First Name	Birth Date (mm/dd/yy)	Gender	Relationship	Tax Dependent
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N
			☐ M ☐ F		☐ Y ☐ N

Section V

Date, Sign and Submit this form to your Benefits/Payroll/Personnel Office

By signing below, I agree that all information is true. I understand that I am enrolling in a voluntary plan and that VSP will automatically deduct the entire monthly vision premiums from my paycheck. I agree to continue enrollment in the vision plan through December 31 of the current calendar year. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.

Date (mm/dd/yy)	Signature

For Office Use Only

Member ID	Hire Date	Location	Coverage/Change Effective Date	Date Received	Received By	Group #

Fax to VSP