



**Smithsonian Institution
VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM**

**Section 1
Employer Use Only**

Name of Group SI Vision Plan Department _____ Effective Date _____

**Section 2
Employee Please Complete** *(Please Print or Type)*

1	SOCIAL SECURITY NO.	MEMBER LAST NAME	MEMBER FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR
	2 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		3 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
4	2 SPOUSE				
	3 CHILDREN (INCLUDE SURNAME IF DIFFERENT)				

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

Employee Signature _____ Date _____