



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