VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT CARD

NAME OF GROUP (EMPLOYER): WCBOE SCHOOL: ____________________

SOCIAL SECURITY NUMBER	LAST NAME FIRST NAME MI	DATE OF BIRTH MM/DD/YYYY

COVERAGE SELECTION: ☐INDIVIDUAL ☐PARENT/CHILD ☐HUSBAND/WIFE ☐FAMILY

I authorize monthly payroll deductions for coverage selection chosen. I agree to remain enrolled for the entire enrollment period, assuming I remain employed. Premium rates for subsequent 12-month renewals are subject to negotiation between my employer and Vision Service Plan.

Signature:____________________ Date: ____________________