VISION SERVICE PLAN

ENROLLMENT FORM

Vincennes University

Group Number: 12183445

Employee Name:____
Last name, first name, middle initial

Employee Social Security Number:________________________

Employee Address:____

Employee Date of Birth:____________________________________

Effective Date of Coverage:_________________________________

_______ **Employee Only**

_______**Employee plus one (spouse OR one child)**

_______**Employee and Children**

_______**Employee and Family**

_______**Terminate coverage(Coverage will term at end of December)**

____
Employee signature/date