

Vision Service Plan (VSP)

Enrollment Application

Group Name: Solano County Office Of Education

Group Number: 0142-0142 Management

0140-0140 Certificated and Classified

Coverage Code: A = Family B = Member +1 C = Member Only (circle one)

Enrollee: _____ Social Security Number _____ - _____ - _____

Mailing Address: _____

Telephone #: (____) _____ - _____ City: _____ State: _____ Zip: _____

Date Employed: Month ___/Day ___/Year _____ Gender: Male Female

Date of Birth: Month ___/Day ___/Year _____ Marital Status: Single Married
 Divorced Separated

Change to Existing Enrollment (Complete all sections that apply):

Name change Add new dependent Delete dependent Address change (See above)

Dependents: Add Delete

Spouse

Last Name (If different)	First Name	Birth Date	Marriage/Divorce Date	Social Security Number
_____	_____	_____	_____	_____ - _____ - _____

Dependents (s):

Last Name (If different)	First Name	Birth Date	(If over 19 years old) Full-time student? Disabled?	Social Security Number
_____	_____	_____	_____	_____ - _____ - _____
_____	_____	_____	_____	_____ - _____ - _____
_____	_____	_____	_____	_____ - _____ - _____
_____	_____	_____	_____	_____ - _____ - _____
_____	_____	_____	_____	_____ - _____ - _____

COBRA ENROLLMENT Qualifying Date: Month ___/Day ___/Year _____

I Understand that I will be required by the employer to pay for COBRA Benefits

Signature (Form must be signed in order to process) _____ Date _____

Revised 6/08