Vision Enrollment Form

Name of group (employer): San Luis Obispo Community College District

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Type of coverage selected:
☐ employee only
☐ employee and one dependent
☐ employee and family
☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child

Dependent last name	Dependent first name	Social Security #	Gender	* Dependent Relationship	Date of birth mm/dd/yyyy
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /
				☐S ☐C ☐H	/ /

Employee Signature: _____ Date: _____

Please return this form to your benefits administrator. Do not return to VSP.