

**VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM**



Name of Group Samford University Active/Cobra Active - 000 Effective Date _____

1	Social Security No.	Last Name / First Name / MI	Date of Birth
2	Address		Email Address
3	Nature of Application: <input type="checkbox"/> New Contract Application <input type="checkbox"/> Cancel Contract <input type="checkbox"/> Add/Remove Dependent		4 Qualifying Event Type: <input type="checkbox"/> New Hire Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Open Enrollment Date Event Occurred: _____

5 Coverage Level and Rates

(✓)	Please check desired level of coverage	Your Rates	
		Bi-monthly	Monthly
	Employee Only	\$ 3.99	\$ 7.98
	Employee +1 Dependent	\$ 7.98	\$15.96
	Employee + Family	\$12.85	\$25.70

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

6	Last Name / First Name / MI	Relationship	Social Security No.	Date of Birth
		Spouse		
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		

Please Return To benefits@samford.edu. Do Not Return To VSP.

Signature _____ **Date** _____