Vision Service Plan Enrollment Form

Please print clearly to avoid registration errors.
Complete and return to Beth Fisher at the Benefits Connection.

Group Name:	Member Company	Your Email Address	Coverage Effective Date:
Benefits Connection			
Social Security Number:	Last Name	First Name	Date of Birth
Address:			
City/State/Zip:			

Coverage Tier (select one):

☐ Employee Only ☐ Employee + One ☐ Family

Do you have dependent children?	☐ Yes ☐ No
Do your dependent children, if over the age of 19, attend school full time?	☐ Yes ☐ No
Are you enrolling your dependents in the VSP Plan?	☐ Yes ☐ No
Does your spouse have a vision plan?	☐ Yes ☐ No
If yes, who is covered?	☐ Yourself ☐ Spouse ☐ Dependent

PLEASE LIST ALL OF YOUR DEPENDENTS (If Employee + One or Family coverage is selected)

Last Name	First Name	Social Security Number	Date of Birth
2) Spouse			
2) Children (include surname if different)			

Signature:	Date:

PLEASE RETURN TO BETH FISHER AT THE BENEFITS CONNECTION OFFICE.

To reach Beth Fisher: Phone 302-294-2059 Fax 302-322-3593 or Email fisherb@ncccc.com