



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):			
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Family ____BASE ____BUY UP PLAN			
Do you have dependent children?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your dependent children, if over the age of 19, attend school full time?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you enrolling your dependents in the VSP Plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your spouse have a vision plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who is covered?		<input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> 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

