SPOKANE EAR NOSE & THROAT CLINIC
VISION SERVICE PLAN

ENROLLMENT FORM

Name of Group (Employer) _____

Employee Name: _____
last name, first name, middle initial

Employee Social Security Number: _____

Employee Date of Birth: _____

Type of coverage selected:

_____Employee only

_____Employee plus one dependent

_____Employee plus children

_____Employee plus family

_____Waive Coverage

_____
Employee Signature

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