



**VISION SERVICE PLAN**

**Enrollment Form**

Name of Group (Employer): University of Iowa Community Medical Services

Employee Name: \_\_\_\_\_  
Please Print (Last name, First name, Middle initial)

Employee Social Security Number: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Type of coverage selected:

- Employee only.....\$11.30
- Employee plus spouse.....\$18.08
- Employee plus children.....\$18.46
- Employee plus family.....\$29.76
- Waive Coverage

|                               |       |
|-------------------------------|-------|
| <b>Dependent Information:</b> |       |
| Spouse Name:                  | _____ |
| SSN:                          | _____ |
| Child Name:                   | _____ |
| SSN:                          | _____ |
| Child Name:                   | _____ |
| SSN:                          | _____ |
| Child Name:                   | _____ |
| SSN:                          | _____ |
| Child Name:                   | _____ |
| SSN:                          | _____ |

\_\_\_\_\_  
Employee Signature

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