VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Group **NACO Benefit Services** Division: Group Name:

1	Social Security No.	Last Name / First Name / MI	Date of Birth:	Gender:
Address – Street, City, State, Zip Code (optional):		Email address (optional):	Telephone (optional):	

2	Are you enrolling your Spouse in the VSP Plan? Y ☐ N ☐ If so, enter Spouse information in Section 5.	3	Are you enrolling your dependent children in the VSP Plan? Y ☐ N ☐ If so, enter child information in Section 5.

4 Coverage Level and Rates

(√)		Monthly Rates
☐	Employee Only	$9.62
☐	Employee + Spouse	$19.31
☐	Employee + Child(ren)	$23.73
☐	Employee + Family	$31.84

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

5

Last Name / First Name / MI	Date of Birth	Gender

Please Return to Your Human Resources Department. Do Not Return to VSP

☐ If this box is checked, I waive the NACO VSP vision coverage, until I would apply during an Open Enrollment period in the future.

Signature_____ **Date**_____

11-2021