VSP Vision care for life

Member Dependent Tracking Enrollment Form

Name of Group (Employer) **Ector County** 30037877

Employee Name: _____

First Middle Initial Last

Employee Address: _____

Address City State Zip

SS Number: _____ **Phone Number:** _____

Gender: ___**Male** ___**Female** **Date of Birth:** _____

Type of coverage selected:	**Plan B**	**Plan C**
_____**Employee only**	**$ 6.16**	**$ 7.27**
_____**Employee and one dependent**	**$10.05**	**$11.52**
_____**Employee and children**	**$10.26**	**$11.76**
_____**Employee and family**	**$16.19**	**$18.96**
_____**Waive Coverage**		

***Dependent Relationship Key**			
S	**Spouse**	**H**	**Handicapped Child**
C	**Child**	**T**	**Student**

Dependent First Name	Dependent Last Name	Dependent Relationship*	Date of Birth	Gender

_____ _____

Employee Signature Date