VISION SERVICE PLAN

ENROLLMENT FORM

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

Name of Group: Cook County School District 130

Employee Name: _____

Employee Address: _____

Employee Birth Date: _____

Employee Social Security Number: _____

Type of coverage selected:

____ Employee only

____ Employee and family

Employees and dependents electing the coverage must remain on the plan the entire contract period.

_____
Employee Signature

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