VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

Name of Group **NIS Nebraska Schools** Division Educational Service Unit 8

1	Social Security No.	Last Name / First Name / MI	Date of Birth

2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Plan? Y ☐ N	**3**	Does your spouse have coverage with VSP? ☐ If Yes, who is covered?

4 Coverage Level and Rates

(√)		Monthly Rates	
☐	Employee Only	$8.20	
☐	Employee + Spouse	$16.43	
☐	Employee + Child(ren)	$17.56	
☐	Employee + Family	$28.09	

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

Signature_____ **Date**_____