VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

12 Month Employees

Name of Group **NIS Nebraska Schools** Division: _____

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

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	$9.42
☐	Employee + Spouse	$18.87
☐	Employee + Child(ren)	$20.17
☐	Employee + Family	$32.27

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**_____