

## Vision Service Plan Membership Enrollment Form

Name of Group: Kirkwood Community College

Effective Date: \_\_\_\_\_

<b>1</b>	First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
<b>2</b>	Coverage you are electing: <input type="checkbox"/> Single <input type="checkbox"/> Family				

Please list all of your dependents (only if you are selecting family coverage)

<b>3</b>	Spouse First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
	Child First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
	Child First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
	Child First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
	Child First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____
	Child First Name	M.I.	Last Name	Social Security Number	Date of Birth ____ / ____ / ____

Please return to Human Resource, 313 Kirkwood Hall. Do not return to Vision Service Plan.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date