VSP Application – Alabama Pharmacy Association

Group Vision Care Plan Employee Enrollment Form

Division: _____(Office Use Only)

Employer: _____

Date of Employment: _____ Plan Effective Date: _____

Employee Name: (Please Print) _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Email Address of Contract holder:_____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Male _____ Female_____

Coverage: _____Employee Only _____Employee + One _____Employee + Family

Names	Last	First	MI	Date of Birth	SSN
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

I hereby apply for coverage under VSP for which I am now entitled or may become entitled under the provisions of the plan. I certify that I am eligible to participate and that the above information is correct. I agree that once enrolled I will remain enrolled during the designated plan period or until I request cancellation in writing to APA directly.

Signature: _____ Date: _____