NORTHWEST STATE COMMUNITY COLLEGE

Enrollment or Change for Vision Insurance (VSP)

Name: ____

Address: ____

____

City **ST** **ZIP**

Social Security #: ______________________________________

Employee Birth Date: ____________________ **Insurance Effective Date:** ______________________

_____ I **DECLINE** available vision coverage

_____ Please **ENROLL** me and my dependents (as listed below)

_____ Please **CHANGE** my enrollment to
____ Single (Employee Only Coverage)
____ Employee + 1 Coverage
____ Family (Employee and 2+ dependents)

_____ Please **CHANGE** my dependent coverage as shown below (drop or add eligible dependents)

_____ Please **TERMINATE** my current coverage effective on: ______________________

DEPENDENT NAME	DROP OR ADD
___________________________________	___________________
___________________________________	___________________
___________________________________	___________________
___________________________________	___________________
___________________________________	___________________

Signature: __________________________________ **Date:** __________________