Enrollment Form

AFT-NH/12245359

Name of group (employer): ____________________

Employee last name, first name, middle initial: ____________________

Social Security Number: ____________________

Gender: ☐ male ☐ female

Date of birth (month/date/year): ____________

Effective Date of Coverage: ____________

Type of coverage selected:

- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and family
- ☐ waive coverage

Employee Signature: ____________________

Please return this form to your benefits administrator. Do not return to VSP.

Please mail completed form to :
AFT-NH
785 Route 3A, Unit 102
Bow, NH 03304