VSP
Vision care for life

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

I am currently a AFT-NH VSP Plan Member _____

Current mailing address _____

_____

current phone and email _____