Enrollment Form

AFT-NH/12245359

Name of group (employer): ______________________________

Employee last name, first name, middle initial: ______________________________

Social Security Number: ______________________________

Gender: ☐ male ☐ female ☐ other

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.

<u>**Please mail completed form to**</u> **:**
AFT-NH
785 Route 3A, Unit 102
Bow, NH 03304

I am a renewing AFT-NH VSP Plan Member updating my contact information _____

Name: ______________________________

New mailing address ______________________________

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New phone and email ______________________________