ENROLLMENT FORM 2026

GROUP NAME: AFT-NH 12245359

INSTRUCTIONS:

- Complete all personal information.
- Select the Plan Coverage you are enrolling in.
- If enrolling in Member + 1 or Family Plan Coverage, complete dependent information.
- Sign and date the form.
- Check payable to: **AFT-NH VSP**, in the amount of: **Plan Coverage Annual Rate**
- Mail completed form and check to: **AFT-NH, 785 Route 3A, Unit 102, Bow, NH 03304**

2026 Open Enrollment Period: *09/28/2026 – 10/28/2026*
Effective Date of Coverage: 11/01/2026

Member Name: _____
FIRST MI LAST

Social Security Number: _____ Date of Birth: _____
NO DASHES MM/DD/YYYY

Gender: ☐ male ☐ female ☐ other Home Email: _____

Home Address: _____ Phone: _____

_____

_____

_____

Plan Coverage (select one)	Annual Rate
☐ Member Only	$170.20
☐ Member + 1	$242.20
☐ Family	$426.40

FOR MEMBER + 1 OR FAMILY PLAN, COMPLETE DEPENDENT INFORMATION
DEPENDENT CHILDREN ARE ELIGIBLE TO PARTICIPATE UP TO 26 YEARS OF AGE

Dependent Name FIRST, MI, LAST	Dependent Relationship (SPOUSE/PARTNER, or CHILD)	Gender M, F, or O	Date of Birth MM/DD/YYYY

Member Signature: _____ Date: _____