

**Vision Plan Application
State of Wisconsin Employee**



Section I

Employee/Applicant Information			
Name (Last, First, MI)			Birth Date (MM/DD/YY)
Address	City	State	ZIP

Section II

Reason for Submitting Application (Check the appropriate reason)	
<input type="checkbox"/>	Initial Enrollment (Complete all Sections)
<input type="checkbox"/>	Open Enrollment (Complete all Sections)
<input type="checkbox"/>	Change of Name or Address (Complete Sections I and V only)
<input type="checkbox"/>	Adding a Dependent [Complete all Sections, listing in Section IV the dependent(s) being added]
<input type="checkbox"/>	Marriage _____ (date)
<input type="checkbox"/>	Domestic Partnership _____ (date)
<input type="checkbox"/>	Birth _____ (date)
<input type="checkbox"/>	Adoption _____ (date)
<input type="checkbox"/>	Other _____ (date)
<input type="checkbox"/>	Deleting Dependent(s)
<input type="checkbox"/>	Death _____ (date)
<input type="checkbox"/>	Domestic Partnership Termination _____ (date)
<input type="checkbox"/>	Divorce _____ (date)
<input type="checkbox"/>	Dependent reached age limit _____ (date)
<input type="checkbox"/>	Other _____ (date)
<input type="checkbox"/>	Canceling Coverage (Complete Sections I and V only)
*Note: Cancellation is effective at the end of the year in which the cancellation form is submitted	
<input type="checkbox"/>	Termination _____ (date)
<input type="checkbox"/>	Other _____ (date)

Section III

Coverage Desired	Monthly Rates
<input type="checkbox"/> Employee/Applicant Only	\$6.54
<input type="checkbox"/> Employee/Applicant + Spouse/Domestic Partner	\$13.08
<input type="checkbox"/> Employee/Applicant + Child(ren)	\$14.73
<input type="checkbox"/> Employee/Applicant + Family	\$23.54

Section IV

Complete the following information ONLY for individuals covered by the policy					
Last Name	First Name	Birth Date (mm/dd/yy)	Gender	Relationship	Tax Dependent
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N

Section V

Date, Sign and Submit this form to your Benefits/Payroll/Personnel Office	
By signing below, I agree that all information is true. I understand that I am enrolling in a voluntary plan and that VSP will automatically deduct the entire monthly vision premiums from my paycheck. I agree to continue enrollment in the vision plan through December 31 of the current calendar year. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.	
Date (mm/dd/yy)	Signature

For Office Use Only

Employee ID	Hire Date	Location	Coverage/Change Effective Date	Date Received	Received By	Group #
						30027840/ 0001 / 0001

FAX VSP, Original - SC, copy - employee, copy - institution/campus