MARGARETTA BOARD OF EDUCATION
VSP ENROLLMENT FORM

☐ Single Coverage

☐ Family Coverage

Employee Name_____

Address_____

_____

Birthday_____

Dependents	Date of Birth
Spouse_____	_____
Children_____	_____
_____	_____
_____	_____
_____	_____

Are you, your spouse, or dependents covered under any other Vision Plan?

_____Yes _____No If yes, Plan Name, name & address of Insurance Co.

_____

_____

I certify the above information to be correct:

_____ _____

Signature Date

I hereby waive coverage under the VSP Vision Plan:

_____ _____

Signature Date