

**VSP VISION INSURANCE
ENROLLMENT / CHANGE APPLICATION**

Name of Employer La Center School District	Group ID # 12061361	Effective Date	
Address PO Box 1840	City La Center	State WA	Zip Code 98629
Work Telephone Number	Occupation	Date of Hire	
Employee Name (Last, First, Middle Initial)	Social Security Number	Telephone Number	
Mailing Address	Date of Birth	Gender	
		M	F
Legal Spouse (Last, First, Middle Initial)	Social Security Number	Gender	
	Date of Birth	M	F
Dependent Child (Last, First, Middle Initial)	Social Security Number	Add	Delete
	Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child (Last, First, Middle Initial)	Social Security Number	M	F
	Date of Birth	Add	Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	<input type="checkbox"/>	<input type="checkbox"/>
	Date of Birth	M	F
Dependent Child (Last, First, Middle Initial)	Social Security Number	Add	Delete
	Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child (Last, First, Middle Initial)	Social Security Number	M	F
	Date of Birth	Add	Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	<input type="checkbox"/>	<input type="checkbox"/>
	Date of Birth	M	F

Employee Signature: _____ Date: _____