



Shickley Public Schools—Vision enrollment form

Employee name: _____

Social Security number: _____ Date of Birth: _____

Gender: M or F Date of Hire: _____ Hours per week: _____

Occupation: _____

Home address: _____ City _____ State: _____ Zipcode: _____

Dependents:

Name	Relationship	Gender	Date of Birth
1. _____	_____	M or F	_____
2. _____	_____	M or F	_____
3. _____	_____	M or F	_____
4. _____	_____	M or F	_____
5. _____	_____	M or F	_____

Plan: (circle one) VSP Plan Eyemed Plan Vision Perfect Freedom of Choice

Coverage selected (circle only one below)

employee only

employee +1

employees + 2 or more

employee signature

date