vsp sm
Vision care for life

Organization Name: **WASHINGTON LOCAL SCHOOLS**   Acct. No.: **12279620001**

I. Check the Appropriate Boxes

COVERAGE DESIRED   WKLY/MO. RATE

☐ No Coverage

☐ Employee Only

☐ Employee + One

☐ Employee + Family

☐ New Enrollment

☐ Change of Status/Address

☐ Open Enrollment

☐ COBRA

REASON FOR CHANGE IN STATUS

☐ Termination
☐ Marriage
☐ Newborn Child
☐ Adoption/legal custody

☐ Other Insurance

☐ Move to COBRA

☐ Death
☐ Divorce
☐ Last Name/Address Change of child
☐ Legal custody of parent
☐ Dependent child married/ reached age limit

II. Employee Information (please print clearly):

Unique Member ID Number/Social Security #: _____ - _____ - _____ Birth Date _____ / _____ / _____

Your Name _____
(First)   (Middle Initial)   (Last)

Address _____

_____

Home Phone (_____) _____ - _____   Work Phone (_____) _____ - _____

III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Sex
Spouse			___/___/___	not applicable	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F

*Your Signature*_____ *Date*_____

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)