Vision Plan Application
City of Gallup Employee

VSP®
Vision care for life

Section I

Employee/Applicant Information	
Name (Last, First, MI) ,	Birth Date (MM/DD/YY)
Social Security Number	Effective Date of Coverage		

Section II

Reason for Submitting Application (Check the appropriate reason)

- ☐ Initial Enrollment (Complete all Sections)
- ☐ Open Enrollment (Complete all Sections)
- ☐ Change of Name or Address (Complete Sections I and V only)
- ☐ Adding a Dependent [Complete all Sections, listing in Section IV the dependent(s) being added]
  - ☐ Marriage _____ (date)
  - ☐ Birth _____ (date)   ☐ Adoption _____ (date)
  - ☐ Other _____ (date)
- ☐ Deleting Dependent(s)
  - ☐ Death _____ (date)   ☐
  - ☐ Divorce _____ (date)   ☐ Dependent reached age limit _____ (date)
  - ☐ Other _____ (date)
- ☐ Canceling Coverage (Complete Sections I and V only)

- ☐ Termination _____ (date)
- ☐ Other _____ _____ (date)

Section III

Coverage Desired	

- ☐ Employee/Applicant Only
- ☐ Employee/Applicant + Spouse
- ☐ Employee/Applicant + Child(ren)
- ☐ Employee/Applicant + Family

Section IV

Last Name	First Name	Birth Date (mm/dd/yy)	Gender	Relationship
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

Section V

Date, Sign and Submit this form to your Human Resources Department	
Signature	
Date (mm/dd/yy)	HR Use Only