



FrankCrum VSP Enrollment Form

CHOOSE THE VISION COVERAGE THAT'S BEST FOR YOU!

Coverage begins the first day of the month after receipt of the enrollment form. Rates cover all administrative costs of the plan. The rates below are monthly. Note that the selected coverage will be deducted from your paycheck on a pre-tax basis each pay period.

EMPLOYEE ONLY	\$ 5.60	<input type="checkbox"/>	EMPLOYEE+ONE	\$11.23	<input type="checkbox"/>
EMPLOYEE+CHILDREN	\$11.99	<input type="checkbox"/>	EMPLOYEE+FAMILY	\$19.20	<input type="checkbox"/>

Employee Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Last four digits of SS# _____ Phone _____

If Choosing Dependent coverage*

Please fill out Dependent Name, Date of Birth and Relationship to the employee. Children/students over 25 do not qualify.

*Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree all information is true and accurate.

Signature _____
(Signature is required to process your application)

Date _____

Please print and complete in full and fax to the FrankCrum Benefits Department at 727.373.0312.