

VISION SERVICE PLAN EMPLOYEE ENROLLMENT

Woodbridge Township School District Group #04485701

PLEASE PRINT

LastName/FirstName: _____

Address: _____

Social Security # _____

Date of Birth _____

Coverage Requested (circle)

Single

Family

Waive

Spouse and/or children to be covered:

Lastname/Firstname

Date of Birth

Lastname/Firstname	Date of Birth

The Vision/Optical Plan is underwritten by the Vision Service Plan, Parsippany, NJ.

Signature of Employee: _____

Date: _____