VSP - MEMBERSHIP ENROLLMENT FORM

Name of Client: City of San Diego **Client Policy ID:** 30057873
Benefits Division: Retirees **Reporting Division: 0002/0002** **Effective Date:**

1	**Employee Last 4 of SSN#**	**Last Name / First Name / MI**	**Email Address**	**Date of Birth (MM/DD/YY)**
2	Do you have dependent children - Y ☐ N ☐ Are you enrolling your dependents in the VSP Cover? Y ☐ N ☐			
3	**Coverage Level** **(Choose one from below)**			

(√)		
☐	$5.94	Subscriber Only
☐	$11.87	Subscriber + One
☐	$13.94	Subscriber + Two or more

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLED IN THE PROGRAM

4	**Surname / First Name / MI**	**Relationship** (Spouse, Child, Disabled Dependent)	**Date of Birth (MM/DD/YY)**	**Add or Delete Dependent**

PLEASE RETURN TO SDCERS MEMBER SERVICES DEPARTMENT

Signature____________________________________ **Date**____________________