



Vision Service Plan Enrollment Form

Name: _____ Date: _____

SS Number: _____ D.O.B.: _____

VSP Start Date: _____ (1st of month following eligibility)

Vision Options

(check one)

Employee (\$9.42 mo.) _____

Employee + One (\$15.08 mo.) _____

Employee + Children (\$15.39 mo.) _____

Employee + Family (\$24.82 mo.) _____

Acceptance of Coverage

By signing below, I understand that changes to my elections can not be made until a life event or open enrollment for the University. I authorize OBU to deduct premiums per payroll deduction schedule.

Signature _____

Date _____

Declining/Cancelation of Coverage

By signing below, I am waiving the opportunity to enroll in vision insurance and understand I will not be able to enroll until next open enrollment.

Signature _____

Date _____