



CCHP

**VSP Vision Plan A \$10/\$25 (12/24/24)
Employee Application**

- New Enrollment
 Adding Dependents

Your employer has select to provide you and your family with VSP vision care through CCHP. Employee subscribers whom currently enrolled in CCHP's medical coverage will be enrolled in VSP Vision Plan. Changes are allowed only during your group's medical open enrollment period.

Group Information

Group / Employer Name	CCHP Group No.	VSP Effective Date
-----------------------	----------------	--------------------

Employee Information (Please Print)

Last Name	First Name	Mi	Employee SSN / CCHP Member ID#	
Home Address				Apt. #
City	State & Zip	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Home Telephone ()	Daytime Telephone ()	Email		

Dependent Information (Please Print)

Relationship	Last Name	First Name	MI
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

Employee Signature

Date