



**DIOCESE OF CHEYENNE EMPLOYEE MEDICAL BENEFIT PLAN
VSP Enrollment Form**

NOTE: If you make a mistake when completing an answer, please correct, initial and date.
NOTICE: A person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime.

PART I - TO BE COMPLETED BY EMPLOYER

Location Name:	City:	Pastor/Admin:
Employee: Last First M.I.	Group # 1859	

Cost per month (eff 1/1/08):		I select coverage for:	
EE only	\$11.34	EE only	
EE + one	\$18.14	EE + one	
EE + Children	\$18.52	EE + Children	
EE + Family	\$29.86	EE + Family	

<input type="checkbox"/> I wish to waive enrollment in the VSP vision program

Signature:
SSN:
Date of Birth:
Address:
City, State, Zip:
Effective Date:

Administrator Approval:
Date:

Version 200803
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