Name of Group  **CONTACT COMMUNICATIONS, INC 2018** Effective Date

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Social Security No. | Last Name / First Name / MI | Date of Birth |
| 2 | Do you have dependent children - Y 🞏 N 🞏Are you enrolling your dependents in the VSP Plan - Y 🞏 N 🞏 | 3 | Does your spouse have coverage with VSP? 🞏 If Yes, who is covered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4 Coverage Level and Rates |
| (**√**) |  | Monthly Rates |
|  |  | Plan  | Your Cost  |
|  | Employee Only | $12.34 | $5.00 |
|  | Employee + Spouse | $19.75 | $12.41 |
|  | Employee + Child(en) | $20.16 | $12.82 |
|  | Employee + Family | $32.51 | $25.17 |
| PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM |
| 5 | Last Name / First Name / MI | Social Security No. | Date of Birth |
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|  |  |  |
|  |  |  |
| Please Return To Kathy Paskevich. Do Not Return To VSP |

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_