PEAK1 ADMINISTRATION

VSP® Vision care for life

Employee Application

☐ **New Employee** **Effective Date**: _____
☐ **Open Enrollment** **Hire Date**: _____
☐ **Change(list type of change)**: _____ **Location:** _____

Employee on Company Health Plan **Employee Not on Company Health Plan**

Employer: _____

Name: _____ **Date of Birth *(required)*:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **SSN: (Required)** _____ ☐Male ☐ Female

COVERAGE OPTIONS

☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

FAMILY MEMBERS

Name	Relationship	Date of Birth	Gender

☐ I decline the vision coverage at this time

_____ _____
Member Signature *Date*