



DEM Group, LLC - Vision Service Plan

Please indicate plan selected: Standard High
(If a plan is not selected you will automatically be enrolled in the High Plan)

CLIENT NAME: _____

Employee's Name: _____
Last First M.I.

Mailing Address: _____
Street Apt. #
_____ City State Zip

Social Security Number: _____ Gender: _____ Date of Birth: _____

Hire Date: _____ Phone Number: _____

Dependent Benefits Requested for:

Spouse: _____
Last First M.I.
Social Security Number: _____ Gender: _____ Date of Birth: _____

Child: _____
Last First M.I.
Social Security Number: _____ Gender: _____ Date of Birth: _____

Child: _____
Last First M.I.
Social Security Number: _____ Gender: _____ Date of Birth: _____

Child: _____
Last First M.I.
Social Security Number: _____ Gender: _____ Date of Birth: _____

Child: _____
Last First M.I.
Social Security Number: _____ Gender: _____ Date of Birth: _____

I hereby apply for the group benefit(s) indicated above. I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance. The information provided above is true and correct to the best of my knowledge.

Employee Signature: _____ Date: _____

(Please sign in this section ONLY if declining coverage)

I decline coverage. I hereby waive VSP Vision coverage offered by this employer.

Employee Signature: _____ Date: _____