VSP VISION APPLICATION

Employer _____

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____

☐ **YES**, I would like to add VSP Vision Insurance effective _____ / _____ / _____.

Please select the vision insurance coverage which you would like to receive.

- ○ Employee Only (Standard)
- ○ Employee Only (Premium)
- ○ Employee + 1 (Spouse or 1 Child) (Standard)
- ○ Employee + 1 (Spouse or 1 Child) (Premium)
- ○ Family (Standard)
- ○ Family (Premium)

☐ **NO**, I do not wish to add VSP Vision Insurance.

Please list all eligible family members (including yourself) which will be covered under your Vision Insurance policy.

Last Name	First Name	Relationship (Self/Spouse/Child)	SS #	Date of Birth	Gender (M or F)
		Self			

Employee Signature _____ Date _____

Submit Your Completed Application To:

FRONTEER PROFESSIONAL SERVICES

Fronteer Professional Services, Inc.
1838 E Interstate Ave Ste B
PO Box 1315
Bismarck, ND 58502
T: (701) 258-9848
F: (701) 258-1011
E: customerservice@fpspayroll.com