



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, Inc.**



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