



MSMS PHYSICIANS INSURANCE AGENCY 877-PIA-ASK-US (742-2758) FAX 517-324-4327

| PLEASE CHECK ONE: | | Practice Name: _____ |
|---|---|---|
| <input type="checkbox"/> New Group Enrollment | REQUEST EFFECTIVE DATE: _____ | Address: _____ |
| <input type="checkbox"/> Total Group Cancel | | City: _____ State: _____ Zip: _____ |
| ADDITION: | | Bus. Phone: (____) _____ Bus. Fax: _____ |
| <input type="checkbox"/> New Employee | CANCEL COVERAGE: | Email: _____ |
| <input type="checkbox"/> Spouse | | MSMS Member Physician Name: _____ Contact Person: _____ |
| <input type="checkbox"/> Child | | County: _____ |
| <input type="checkbox"/> Subscriber & Dependent | | |
| <input type="checkbox"/> Spouse | | |
| <input type="checkbox"/> Child | | |

| SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 3 | | | | |
|---|----------------------------|--|---------------------------------|---------------|
| SECTION 1 | Subscriber Social Security | Subscriber Last Name | Subscriber First Name | MI |
| | Address | City | State | Zip |
| | County | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth ____/____/____ | Email Address |

| List all persons to be enrolled / terminated: | | | | | | | |
|---|------------|---------------|------------|----|-----|---------------------------------|-------------------|
| | CIRCLE ONE | LAST NAME | FIRST NAME | MI | SEX | Date of Birth ____/____/____ | SOCIAL SECURITY # |
| SUBSCRIBER SECTION 2 | Subscriber | Add Delete | | | | ____/____/____ | |
| | Spouse | Add Delete | | | | ____/____/____ | |
| | Dep-1 | Add Delete | | | | ____/____/____ | |
| | Dep-2 | Add Delete | | | | ____/____/____ | |
| | Dep-3 | Add Delete | | | | ____/____/____ | |
| | Dep-4 | Add Delete | | | | ____/____/____ | |
| | | | | | | | ____/____/____ |

| | | |
|----------------------------|----------------------|----------------|
| SIGNATURE SECTION 3 | Subscriber Signature | Signature Date |
| | | |

| | | |
|------------------|-------------------------|------------------------|
| SECTION 3 | VSP Vision Group/Suffix | |
| | ENROLLMENT: | Effective Date: |
| | REASONS FOR CHANGE: | Effective Date: |
| | CANCEL COVERAGE: | Last Date of Coverage: |

- IMPORTANT INFORMATION -**
- ★ Subscribers are required to remain enrolled for a minimum of 12 consecutive months or unless terminated by employer.
 - ★ All employees must choose the same plan. Physicians are free to choose either plan regardless of what other employees or physicians have selected.
 - ★ **SUBSCRIBER NAME AND SOCIAL SECURITY NUMBER MUST BE FILLED OUT TO PROCESS**

| SURVIVING SPOUSE ONLY | |
|---------------------------------|-------------------------------|
| Name of DECEASED: _____ | |
| Social Security Number: _____ | Date of Death: ____/____/____ |
| Name of SURVIVING SPOUSE: _____ | |
| Billing Address: _____ | |
| Social Security Number: _____ | Date of Death: ____/____/____ |
| Signature: _____ | |

Check choice of coverage:

Bronze _____ Silver _____ Gold _____

| |
|----------------------------------|
| MSMS Member Physician Signature: |
| _____ |
| Date: _____ |