WAIVER FORM

I hereby certify that I understand that I am eligible for the vision program administered by VSP (Vision Service Plan).

I decline to participate in this program.

Name _____

Signature _____

Social Security Number _____

Name of Employer **Muskingum University**

If VSP (Vision Service Plan) coverage is waived because of coverage through another source:

Name of Other Vision Carrier _____

Subscriber's Name _____