



## Enrollment Form with Dependent Data

Name of group (employer): \_\_\_\_\_

Employee last name, first name, middle initial: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employee Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of birth (month/date/year): \_\_\_\_\_

Gender:  male  female

Type of coverage selected:  employee only  employee and one dependent  employee and child(ren)  
 employee and family  waive coverage

Effective Date of Coverage: \_\_\_\_\_ \* **Dependent Relationship:** S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /

Employee Signature: \_\_\_\_\_

Please return this form to your benefits administrator. Do not return to VSP.