Enrollment Form with Dependent Data

Name of group (employer): ______________________________

Employee last name, first name, middle initial: ______________________________

Social Security Number: ______________________________

Gender: ☐ male ☐ female   Date of birth (month/date/year): ____________________

Effective Date of Coverage: ____________________

Plan Options: ☐ Standard ☐ Premium   Type of coverage selected: ☐ employee only
☐ employee and one dependent
☐ employee and children
☐ employee and family
☐ waive 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
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: ______________________________

Please return this form to Kelsey Brewer. Do not return to VSP.