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: ____________________
(To be completed by employer)

* **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: ____________________ Date: ____________________

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