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 Action: ☐ add ☐ terminate ☐ change

Type of coverage selected: ☐ employee only
☐ employee and family ☐ waive coverage

Effective Date: _____ *** Dependent Relationship**: S=spouse, C=child, H=handicapped child

Dependent last name	Dependent first name	Gender	Date of Birth	*Dependent Relationship	Action	Dependent SSN
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	
			/ /	☐S ☐C ☐H	☐ add ☐ terminate	

Employee Signature: _____

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