



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

Plan Type (please circle one) : Standard

Premium

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

Effective Date of Termination: _____
T=student

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

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 your benefits administrator. Do not return to VSP.