

## **Enrollment Form with Dependent Data**

Name of group	o (employer):			
Employee last name, first name, middle initial:				
Social Secu	rity Number:			
Employee Ho	ome Address:			
Email Address:	Date of	Date of birth (month/date/year):		
Gender:  male female				
	loyee and family \(\subseteq\) waive (	d one dependent  coverage	employee and child(ren	)
Effective Date of Coverage: * Dependent Relationship			S=spouse, C=child, H=handicap	T
dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
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]	Employee Signature:			

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