



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: _____ * **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
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
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			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /

Employee Signature: _____

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