

Enrollment Form with Dependent Data

Name of group (employer):					
Employee last name, first name,	middle initial:				
Social Security Number:					
Employee H	ome Address:				
Email Address:		Date of birth (month/date/year):			
Gender: male female					
Type of coverage selected: emp	loyee only	ee and one de vaive coverage	ependent [employee and child(ren	1)
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
				□S □C □H □T	/ /
				□s □c □H □T	/ /
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				□s □c □H □T	/ /
	Employee Signature:				

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