



# Enrollment Form

Name of group (employer): \_\_\_\_\_

Employee last name, first name, middle initial: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Gender: ☐ male ☐ female

Date of birth (month/date/year): \_\_\_\_\_

Effective Date of Change: \_\_\_\_\_

Type of coverage selected:

☐ employee only

☐ employee and child(ren)

☐ employee and family

☐ waive coverage

Type of change selected:

☐ employee terminated

☐ add dependent / spouse

indicate reason: \_\_\_\_\_

**\* 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	/ /
			<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	/ /

Employee Signature: \_\_\_\_\_

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