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 |
|  |  |  | 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.