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 birthmm/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.