Vision Enrollment Form with Dependent Data

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 Coverage: ____________________

Type of Coverage Selected:
☐ Employee only
☐ Employee + one dependent
☐ Employee + family

* **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: ______________________________ Date: ______________________________

Please return this form to Human Resources