



Enrollment Form with Dependent Data

Retiree Name (first and last): _____

Social Security Number: _____

Date of birth (mm/dd/yyyy): _____ Gender: male female other

Type of coverage selected: employee only employee and one dependent employee and child(ren)
 employee and family waive coverage

Coverage Start Date: _____ **Choose one:** Base Plan _____ Buy Up Plan _____

Please list all dependents who will be enrolled in the program. * **Dependent Relationship:** S=spouse, C=child, H=handicapped child, T=student

Dependent first name	Dependent last name	* Dependent Relationship	Gender	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		/ /

Retiree Signature: _____

Please return this form to SBCERS. Do not return to VSP.

Office Use Only

Group Name:	Client ID (8-digits):
Division Name:	Division ID (4-digits):