



# Enrollment Form with Dependent Data

Name of group (employer): **Doane University**

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

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

Gender:  male  female

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

Effective Date of Coverage: \_\_\_\_\_

Plan Options:  Standard  Premium    Type of coverage selected:  employee only  
 employee and one dependent  
 employee and children  
 employee and family  
 waive 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
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /

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

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