ENROLLMENT FORM WITH DEPENDENT DATA

EFFECTIVE DATE: _____

Employee last name, first, middle initial: _____

Employee SSN: _____

Complete dependent information and place a check mark next to each plan you want to enroll your dependent in.

| Dependent last name | Dependent first name | D.O.B | Gender | Relationship | SSN | Medical | Dental | Vision |
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**Please refer to the backside of this page for a list of supporting documents required to add dependents**

Authorizations for Group Medical Plan Benefits: I, for myself and on behalf of my eligible dependents listed above, hereby agree to the conditions of enrollment attached hereto and apply for enrollment in the benefit plans listed above. The above information is true and complete to the best of my knowledge. I have acknowledged the terms and conditions.

Employee Signature: _____ Date: _____