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

Please refer to Supporting Documents Tab for required documents to add dependent coverage

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: _____

SUPPORTING DOCUMENTS REQUIRED TO ADD DEPENDENT COVERAGE:

Legal Spouse/Domestic Partner:

- **Social Security Card (copy)**
- **Marriage Certificate copy front and back/Declaration of Informal Marriage (Common Law)**
- **Latest Tax Returns or Joint Financial Statement**

Dependent Child(ren) Biological, Adopted, or Legal Guardian:

- **Social Security Card (copy)**
- **Birth Certificate (copy)**

Stepchildren:

- **Social Security Card (copy)**
- **Birth Certificate (copy)**
- **Marriage Certificate (copy front and back)**

Adopted/Court ordered dependents:

- **Social Security Card (copy)**
- **Adoption/Guardianship Documents (copy)**
- **Custody/Court Order Documents (copy)**

**** FAILURE TO TURN IN THESE DOCUMENTS MAY RESULT IN DEPENDENTS NOT HAVING COVERAGE.**