# DEPENDENT ENROLLMENT FORM

Commerce CITY

*Please print legibly*

Name _____    Social Security Number _____

Department _____    Phone # _____    Gender _____

Date _____

> **Fax your form to: 303-227-8773 OR email to**
> **(do not do both):HR2@c3gov.com**

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**DEPENDENT INFORMATION – Must be a dependent as defined in the most current Benefits Guide**
**Please note, that adding a dependent on this form DOES NOT automatically add them to your benefits. You must add your depedents to your benefit coverage through the open enrollment portal.**

### Spouse

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Legal Spouse  ☐ Common Law Spouse  ☐ Domestic Partner

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

### Dependent(s)

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Check if disabled

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Check if disabled

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Check if disabled

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Check if disabled

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

☐ Add
☐ Remove

**Full Name** (Include Middle Initial) _____
☐ Check if disabled

**Social Security #** __ __ — __ __ — __ __ __ __
**Date of Birth** __ __ / __ __ / __ __
**Gender** ☐ Male  ☐ Female

**ENROLLMENT SIGNATURE** - The information provided on this form is true and correct to the best of my knowledge. I understand that City of Commerce City may take monetary and disciplinary action (up to termination) against me if I enroll individuals as dependents that are not eligible and/or provide false infomation.

**Signature:** _____    **Date:** _____

FORM 1