Enrollment Form with Dependent Data

Name of Group: Greenbush Health / 12079363

Name of Employer: KSGB TWIN VALLEY #240 2054

Employee Last Name, First Name, Middle Initial: ______

Social Security Number: ______

Employee Home Address: ______

Email Address: ______ Date of Birth (month/date/year): ______

Gender: ☐ Male ☐ Female

Type of coverage selected: ☐ Employee Only ☐ Employee and One Dependent (Spouse) ☐ Employee and Child(ren) ☐ Employee and Family ☐ Waive Coverage

Effective Date of Coverage: ______

Dependent Last Name	Dependent First Name	Gender	Dependent Relationship	Date of Birth mm/dd/yyyy
			SPOUSE	
			CHILD	
			CHILD	
			CHILD	
			CHILD	
			CHILD	
			CHILD	

Employee Signature: ______

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

Classification: Confidential