Enrollment Form with Dependent Data

Name of group (employer): ___Jamestown Public Schools_____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

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
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	

Employee Signature: _____

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