Enrollment Form with Dependent Data

Name of group (employer): San Leandro Unified School District

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ Male ☐ Female

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

Effective Date of Coverage: _____

Type of coverage selected:

☐ Employee only
☐ Employee and one dependent
☐ Employee and family

*** 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.