Enrollment Form with Dependent Data

Name of group (employer): **Dakota County**

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ Male ☐ Female

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

Type of coverage selected:

BASIC

Monthly Contribution:

- ☐ Employee only $9.47
- ☐ Employee and one dependent $15.15
- ☐ Employee and children $15.46
- ☐ Employee and family $24.93

PREMIUM

Monthly Contribution:

- ☐ Employee only $18.29
- ☐ Employee and one dependent $29.27
- ☐ Employee and children $29.88
- ☐ Employee and family $48.17

☐ 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	/ /

Employee Signature: _____ Date: _____

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