



# Enrollment/Change Form

Name of group (employer): CLINTON COUNTY

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 family
  - waive coverage

**\* Dependent Relationship:** S=spouse, C=child, H=handicapped child

DEPENDENT LAST NAME	DEPENDENT FIRST NAME	S.S. NUMBER	M/F	ADD	DROP	* DEPENDENT RELATIONSHIP	DATE OF BIRTH mm/dd/yyyy
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /
						<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H	/ /

Employee Signature: \_\_\_\_\_

Please return this form to Human Resources. Do not return to VSP.