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
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /
						☐S ☐C ☐H	/ /

Employee Signature: _____

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