

Enrollment Form with Dependent Data

Name of group (employer):		School District	of Spring Valle	Ÿ	
Employee last name, first nam	e, middle initial:				
Social S	Security Number:				
Employee	e Home Address:				
Email Address:	Date of birth (month/date/year):				
<mark>Gender</mark> : ☐ male ☐ female					
Type of coverage selected: e	mployee only			employee and child(ren)
Effective Date of Coverage: Dependent table must be filled out comp			nt Relationship: S	S=spouse, C=child, H=handicapp	ed child, T=student
dependent last name	dependent first r	name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
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Employee Signature:

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