Dependent Tracking Enrollment Form

Name of group (employer):

Employee last name, first name, middle initial: ____________________

Employee Address: ____________________

Social Security Number: ____________________ Email Address: ____________________

Gender: ☐ male ☐ female

Plan Selection: ____________________ Effective Date ____________________

Date of birth (month/date/year): ____________________ Plan Cost ____________________

Type of coverage selected:
- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and children
- ☐ employee and family
- ☐ waive coverage
- ☐ TERM coverage
- ☐ COBRA coverage Effective Date: ____________________

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

dependent last name	dependent first name	gender	* Dependent Relationship	Social Security #	date of birth mm/dd/yyyy
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			☐S ☐C ☐H ☐T		/ /
			☐S ☐C ☐H ☐T		/ /
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			☐S ☐C ☐H ☐T		/ /

Employee Signature: ____________________