



Enrollment Form Vision and Dental

Full Name

SSN

Date of Birth

Phone

Address 1

Address 2

City

State/Province

Zip/Postal Code

Email

Dental Coverage Level

- Waive
- Employee Only
- Employee & Child(ren)
- Employee & Spouse
- Family

Vision Coverage Level

- Waive
- Employee Only
- Employee & Child(ren)
- Employee & Spouse
- Family

Dependent #1 Full Name

Dependent #1 SSN

Enrollment Election Dependent #1

- Dental Only
- Vision Only
- Dental and Vision

Dependent Date of Birth

Dependent Relationship

- Spouse
- Child

Dependent #2 Full Name

Dependent SSN

Dependent Date of Birth

Dependent Relationship

- Dental Only
- Vision Only
- Dental and Vision

- Spouse
- Child

Dependent #3 Full Name

Dependent SSN

Enrollment Election Dependent #3

- Dental Only
- Vision Only
- Dental and Vision

Dependent Date of Birth

Dependent Relationship

- Spouse
- Child

Dependent #4 Full Name

Dependent SSN

Enrollment Election Dependent #4

- Dental Only
- Vision Only
- Dental and Vision

Dependent Date of Birth

Dependent Relationship

- Spouse
- Child

Dependent #5 Full Name

SSN

Enrollment Election Dependent #5

- Dental Only
- Vision Only
- Dental and Vision

Date of Birth

Dependent Relationship

- Spouse
- Child

Signature

Date