Enrollment Form with Dependent Data

Name of group (employer): Manchester Town & BOE

Employee First & Last Name: ______________________

Social Security Number: ______________________

Employee Home Address: ______________________

Email Address: ______________________ Date of birth (mm/dd/yyyy): ______________________

Gender: ☐ male ☐ female ☐ other

Type of Coverage Selected: ☐ EE only ($5.63) ☐ EE+Spouse ($11.25) ☐ EE+Child(ren) ($12.04) ☐ Family ($19.24)
w/Monthly Rate

Effective Date of Coverage: January 1, 2024

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

dependent first name	dependent last name	gender	*dependent relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: ______________________

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

Classification: Confidential