Enrollment Form with Dependent Data

Name of group (employer): Town of Uxbridge

Employee Name and address: _____

Social Security Number: _____

Email address: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Type of coverage selected:
☐ employee only $7.17 per month
☐ employee and family $15.41 per month
☐ waive coverage

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

dependent last name	dependent first 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 Lisa Yaroshefski. Do not return to VSP.

PLEASE NOTE: VSP does not send cards. Provider will use your social security number for subscriber number.