Ameritas.

Mitchell SD 17 2
Vision Enrollment Form with Dependent Data

Employee last name, first name, middle initial: _____

Address:_____ City: _____ State _____ Zip _____

Social Security Number: _____ Phone: _____

Gender: ☐ male ☐ female   Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected:
☐ employee only ($9.12)
☐ employee and one dependent ($19.68)
☐ employee and children ($15.92)
☐ employee and family ($26.48)
☐ 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: _____Date_____

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