

VSP Enrollment

Effective Date of Coverage
Family Indicator Code

Group Name: MiraCosta College	Group # 00 712201 0010 0010
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A ENROLLEE (Complete this section for new enrollment or change of status)

Name	Social Security Number	Action Requested		Date Employed / / Month Day Year
		<input type="checkbox"/> New Enrollment	<input type="checkbox"/> COBRA enrollment	
		<input type="checkbox"/> Change in enrollment		

Address	Telephone Number ()
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City	State	ZIP code
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Birthdate / /	Sex	Marital Status	Do you have dependent children? Yes No	Employee Classification	
	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Single <input type="checkbox"/> Married** <input type="checkbox"/> Divorced**	<input type="checkbox"/> Academic <input type="checkbox"/> Classified <input type="checkbox"/> Retiree
		**Date			

COBRA Enrollment
I understand that I will be required by the employer to pay for COBRA benefits.

NOTE: If dependent is enrolling under own social security number, the original member's social security number must be supplied.

Qualifying Date _____

Benefits previously received under Social Security Number _____ Month/Day/Year

B Change to Existing Enrollment (Complete all sections that apply)

<input type="checkbox"/> Name change	Reason for change:
<input type="checkbox"/> Add new dependent	
<input type="checkbox"/> Delete dependent	Qualifying Date:
<input type="checkbox"/> Address change listed above	

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name			Add/ Delete	Sex M F	Birthday Month/Day/Year	Marriage/Divorce Date Month/Day/Year	Spouse's Social Security Number	
Last (if different)	First	Middle Initial						
					/ /	/ /		
Child Name			Add/ Delete	Sex M F	Birthdate Month/Day/Year	If child is 19 years or older (check one)		Child's Social Security Number
Last (if different)	First	Middle Initial				Full-time Student	Disabled	

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits.

Enrollee Signature _____ Date _____