PETALUMA CITY SCHOOLS
Vision Service Plan

GROUP INSURANCE ENROLLMENT FORM

ENROLLMENT INFORMATION (Employee):

Employee Name: ______________________________

Effective Date: ______________________ Date of Employment: ______________________

Social Security Number: ______________________

Date of Birth: ______________________ Gender: ☐ Male ☐ Female ☐ Nonbinary

Home Address: ______________________________

City, State, Zip: ______________________________

ENROLLMENT INFORMATION (Dependents):

Name	Date of Birth	SSN	Relationship
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child
			☐ Spouse/Domestic Partner ☐ Adult Dependent ☐ Child

Employee Signature: ______________________________ Date: ______________