Employee Dependent Health Coverage Enrollment Sheet

Employee Information

Full Name

Employee ID

Department

Phone Number

Email Address

Coverage Type Select

Dependent Information

Full Name	Relationship	Date of Birth	Gender	Social Security Number
			Select	
			Select	
			Select	
			Select	

Certification and Authorization

I certify that the above information is true and complete to the best of my knowledge. I authorize my employer to process this enrollment sheet for dependent health coverage.

Employee Signature

Date