

Group Name: Santa Rosa County Commission

Please complete the following information:				
Social Security No.	Last Name	First	Middle	Date of Birth
Home Address		Home Phone		Gender
City	State	ZIP Code	Business Phone	
List All Your Eligible Dependents That Are To Be Covered				
First	MI	Last	Sex	Birth Date
Spouse:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Effective Date:	Plan Code:	Group Number 767846	Your E-mail Address	Agent Number

PLEASE CHECK YOUR CHOICE	<input type="checkbox"/> Vision Plan
Monthly Rates	
Employee Only	<input type="checkbox"/> \$6.76
Employee + Family	<input type="checkbox"/> \$19.34

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____