Enrollment Form with Dependent Data (March 1, 2024 – February 28, 2026)

Vision care for life

Name of group (employer): **Dakota County**

Employee last name, first name, middle initial: _____

Date of Birth (month/date/year): _____ Social Security Number: _____

Address: _____

Phone Number: _____

Email Address: _____

Gender: ☐ Male ☐ Female

Type of coverage selected:

BASE PLAN

Monthly Contribution:

- ☐ Employee only $9.77
- ☐ Employee and one dependent $15.63
- ☐ Employee and children $15.96
- ☐ Employee and family $25.73

PREMIER PLAN

Monthly Contribution:

- ☐ Employee only $19.17
- ☐ Employee and one dependent $30.68
- ☐ Employee and children $31.32
- ☐ Employee and family $50.49

Premiums taken bi-weekly a month in advance.

☐ **Waive coverage**

*** Dependent Relationship**: S=Spouse, C=Child, H=Handicapped Child, T=Student

Dependent First Name	Dependent Last Name	Social Security Number	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	/ /

Employee Signature: _____ Date: _____

Please return this form to the County Clerk's office. **Do not return to VSP**.