



Enrollment Form with Dependent Data

Name of group (employer): University of North Alabama

Employee last name, first name, middle initial: _____

Social Security Number: XXX-XX-XXXX

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Effective Date of Coverage: March 1, 2020

Type of coverage selected: ☐ employee only; \$14.48 per month
☐ employee and one dependent; \$20.99 per month
☐ employee and family; \$37.63 per month

* **Dependent Relationship:** S=spouse, C=child

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C	/ /

Employee Signature: _____

Please return this form to the Office of Human Resources (UNA Box 5043).