



Enrollment Form with Dependent Data

Name of group (Employer): UNIVERSITY OF NORTH ALABAMA

Employee Name: (last, first, middle): _____

Social Security Number: XXX-XX- _____ Gender: Male Female

Date of Birth (MM/DD/YYYY): _____ Effective Date of Coverage: _____

- Type of coverage selected:
- Employee Only; \$8.88 per month
 - Employee and One Dependent; \$17.76 per month
 - Employee and Family; \$23.76 per month

DEPENDENT LAST NAME	DEPENDENT FIRST NAME	GENDER	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	/ /

Employee Signature: _____

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