# Blind Vendor Health Insurance Enrollment Form

Vendor Name:

## DEPENDENTS

1) Dependent's Name:
   Dependent's Date of Birth:
   Dependent's Relationship to You:

2) Dependent's Name:
   Dependent's Date of Birth:
   Dependent's Relationship to You:

3) Dependent's Name:
   Dependent's Date of Birth:
   Dependent's Relationship to You:

4) Dependent's Name:
   Dependent's Date of Birth:
   Dependent's Relationship to You:

## INSURANCE INFORMATION

IF COVERED BY INSURANCE PLEASE LIST COMPANY NAME, ADDRESS, PHONE NUMBER, AND IDENTIFICATION/ENROLLMENT NUMBER BELOW

Company Name:

Company Address:

Company Phone Number:

Identification/Enrollment Number:

Names of Dependents Covered by Insurance:

PER BUREAU POLICY #02-10 HEALTH INSURANCE

YOU ARE REQUIRED TO SUPPLY THE BUREAU WITH THE FOLLOWING INFORMATION: BIRTH RECORDS, MARRIAGE LICENSE, AND SOCIAL SECURITY NUMBERS OF EACH DEPENDENT.

IF THE DEPENDENT IS OVER 18 AND ENROLLED IN A POST-SECONDARY EDUCATION PROGRAM YOU ARE REQUIRED TO SHOW PROOF OF ENROLLMENT IN PROGRAM.

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|---|---|
| _____ | _____ |
| Signature | Date |