Enrollment Form with Dependent Data (July 1, 2026 - June 30, 2028)

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 $10.73
- ☐ Employee and one dependent $17.16
- ☐ Employee and children $17.52
- ☐ Employee and family $28.24

PREMIER PLAN

Monthly Contribution:

- ☐ Employee only $19.71
- ☐ Employee and one dependent $31.54
- ☐ Employee and children $32.19
- ☐ Employee and family $51.90

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.**