Open Enrollment Form with Dependent Data

Name of group (employer): Newport Public Schools

Employee last name, first name, middle initial: _____

Social Security Number: _____

Employee Home Address: _____

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

Gender: ☐ male ☐ female

Type of coverage selected: ☐ employee only ☐ employee and one dependent ☐ employee and child(ren)
☐ employee and family

Effective Date of Coverage: 1/1/2024   *** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

Dependent last name	Dependent first name	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	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to HR@npsri.net by 12/31/2023. Do not return to VSP.