



MEMBERSHIP ENROLLMENT FORM
SHERMAN INDEPENDENT SCHOOL DISTRICT
GROUP NO.: 30009196

Employee Name: _____

Employee Date of Birth: _____

Employee Social Security Number: _____

Date of Hire: _____

Dependent Information	Name	Date of Birth	Relationship

I Elect the Following Coverage:

Employee Only Coverage: \$8.46 Yes

Employee & Spouse \$13.40 Yes

Employee & Child(ren) \$13.66 Yes

Employee & Family \$22.04 Yes

WAIVER OF COVERAGE: I have been given the opportunity to apply for group vision insurance, but:

_____ Do not choose to elect this coverage.

Signature

Date