City of Rockledge
Benefit Selection Form

Employee Information				Department:
Social Security Number	Last Name, First Name, M.I.			Home Telephone ( )
Date of Birth	Marital Status	Date of Hire		Sex M ☐ F ☐
Home Address	Apt. No.	City, State		Zip Code

Health Election	Self Only ☐	Self + 1 ☐	Family ☐		
	Last Name, First Name, M.I.		Social Security Number	Date of Birth MM DD YYYY	Sex M F
Employee					☐ ☐
Spouse					☐ ☐
Child					☐ ☐
Child					☐ ☐
Child					☐ ☐
Child					☐ ☐

Dental Election	Self Only ☐	Self + 1 ☐	Family ☐		
Enroll Same As Above ☐ Enroll As Follows:					
	Last Name, First Name, M.I.		Social Security Number	Date of Birth MM DD YYYY	Sex M F
Employee					☐ ☐
Spouse					☐ ☐
Child					☐ ☐
Child					☐ ☐
Child					☐ ☐
Child					☐ ☐

Vision Election	Self Only ☐	Self + 1 ☐		Family ☐
No Vision Coverage ☐				
Employee Signature - Required				Date
X				/ /