Hancock County Government
Dependent Election Form
Effective: January 1, 2018

Employee Name: _____ **Employee DOB:** _____

Employee SSN: _____ - _____ - _____

Please complete the following information for each person who is to have coverage. Check the coverage selected for each.

Relationship	First Name	M.I.	Last Name	SSN	DOB	Medical Coverage	Dental Coverage	Vision Coverage
Employee								