

This form must be completed if you answered “yes” to any of the questions in the dependent information (2.) section of the Enrollment Application/Change Form. Please complete only the sections that pertain to your covered dependents and attach to your completed Enrollment Application/Change form for enrollment. Please be sure to sign the back of this form.

Applicant last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		First name:	Middle name:
Applicant Social Security Number:			
Is the address for dependents different from the primary residence address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Dependent 1 Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:
Residential address:			
City:	State:	ZIP:	
Home phone:		County:	
Dependent 2 Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:
Residential address:			
City:	State:	ZIP:	
Home phone:		County:	
Dependent 3 Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:
Residential address:			
City:	State:	ZIP:	
Home phone:		County:	
Dependent 4 Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:
Residential address:			
City:	State:	ZIP:	
Home phone:		County:	
Do any dependents have other group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Dependent name:	Social Security Number:		Date of birth: / /
Insurance company name:		Insurance policy ID #:	
Insurance company address:		Type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx	

Do any dependents have a custodial parent who is responsible for their care? <input type="checkbox"/> Yes* <input type="checkbox"/> No If yes:			
Dependent name:		Social Security Number:	
Date of birth: / /			
Last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		First name:	Middle name:
Residential address:			
City:		State:	ZIP:
Home phone:		County:	
Is there someone who is financially responsible for the dependent? <input type="checkbox"/> Yes* <input type="checkbox"/> No If yes:			
Dependent name:		Social Security Number:	
Date of birth: / /			
Organization/last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		First name:	Middle name:
Residential address:			
City:		State:	ZIP:
Home phone:		County:	
Are any dependents continuing coverage as full-time students? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Dependent student name:		Student Social Security Number:	
Date of birth: / /			
Dependent marital status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married/date of marriage: / /			
Dependent employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Dependent student status: <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student	
School enrollment date: / /		Expected date of graduation: / /	
When your dependent child is no longer a full-time student, you must notify your employer through which you are enrolled. Failure to do so may result in the dependent not being able to continue his or her coverage on a direct payment basis without a lapse in coverage. Certification is required on an annual basis.			
Is anyone covered on this application disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Disability type:	Disability begin date: / /		Disability end date: / /
Disabled dependent name:		Social Security Number:	
Date of birth: / /			
Does he/she have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has Medicare paid as primary due to disability before you became eligible due to hemodialysis beginning with the 19 th /31 st month of Medicare ESRD coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is anyone covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Dependent name:		Social Security Number:	
Date of birth: / /			
Medicare/HIC#:			
Do you have Medicare Part A?	Part A begin date: / /		Part A end date: / /
Do you have Medicare Part B?	Part B begin date: / /		Part B end date: / /
If you have a disabled child over the dependent age limit, please complete a disabled dependent application, which can be obtained from your group administrator or by calling our service representatives at 1-800-829-8599, or for the hearing-impaired, (TTY) 1-866-280-0486.			
Signature of applicant: _____			Date: _____
Signature of group administrator: _____			Date: _____

*A copy of a court-initiated document must be attached to this form.