

Additional Dependent Addendum

This form must be attached to a completed enrollment application/change form. Please print clearly. Signature is required. For each additional dependent only complete fields below the dotted line if applicable to the product you are enrolling in.

Section 1: Subscriber's Information

Group #	Subscriber's Last Name	First Name	MI	SSN
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Section 2: Additional Dependent(s) Information

Dependent Child Disabled Dependent Child (Separate application form required) Other _____

Last Name (if different)	Title	First Name	MI	Social Security Number
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Birthdate ____ / ____ / ____		Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____
Is dependent a full time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide name of college/university _____		Expected Graduation Date: ____ / ____ / ____
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate reason <input type="checkbox"/> Age 65+		<input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal	<small>* form required</small>
Medicare Number (if applicable) _____	Part A Effective Date: ____ / ____ / ____		Part B Effective Date: ____ / ____ / ____	
Primary Care Physician's Last Name	First Name	Zip Code	Ob/Gyn's Last Name	First Name Zip Code

Dependent Child Disabled Dependent Child (Separate application form required) Other _____

Last Name (if different)	Title	First Name	MI	Social Security Number
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Birthdate ____ / ____ / ____		Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____
Is dependent a full time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide name of college/university _____		Expected Graduation Date: ____ / ____ / ____
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate reason <input type="checkbox"/> Age 65+		<input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal	<small>* form required</small>
Medicare Number (if applicable) _____	Part A Effective Date: ____ / ____ / ____		Part B Effective Date: ____ / ____ / ____	
Primary Care Physician's Last Name	First Name	Zip Code	Ob/Gyn's Last Name	First Name Zip Code

Dependent Child Disabled Dependent Child (Separate application form required) Other _____

Last Name (if different)	Title	First Name	MI	Social Security Number
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Birthdate ____ / ____ / ____		Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____
Is dependent a full time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide name of college/university _____		Expected Graduation Date: ____ / ____ / ____
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate reason <input type="checkbox"/> Age 65+		<input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal	<small>* form required</small>
Medicare Number (if applicable) _____	Part A Effective Date: ____ / ____ / ____		Part B Effective Date: ____ / ____ / ____	
Primary Care Physician's Last Name	First Name	Zip Code	Ob/Gyn's Last Name	First Name Zip Code

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____