Additional Dependent Children

(Attach securely to Enrollment Form)

Member SSN

Dependent Children Information (Details required even if waiving coverage, due to being covered under group life coverage)

Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth / / **SSN** ◯ Disabled Dependent

Relationship

Health Plan Option Medical/Rx ◯ Yes ◯ No Dental ◯ Yes ◯ No Vision ◯ Yes ◯ No

If child is over the age of 18, has the child had coverage through another plan in the past 63 days? ◯ Yes ◯ No *If yes, please attach a Certificate of Coverage from the previous health plan.*

Do you want this child to be a beneficiary of your life insurance? ◯ Yes ◯ No ◯ Primary ◯ Secondary % of Benefit

Authorization to release Protected Health Information (PHI) Do you authorize the Plan Administrative Office to speak with this child on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to your child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

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Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth / / **SSN** ◯ Disabled Dependent

Relationship

Health Plan Option Medical/Rx ◯ Yes ◯ No Dental ◯ Yes ◯ No Vision ◯ Yes ◯ No

If child is over the age of 18, has the child had coverage through another plan in the past 63 days? ◯ Yes ◯ No *If yes, please attach a Certificate of Coverage from the previous health plan.*

Do you want this child to be a beneficiary of your life insurance? ◯ Yes ◯ No ◯ Primary ◯ Secondary % of Benefit

Authorization to release Protected Health Information (PHI) Do you authorize the Plan Administrative Office to speak with this child on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to your child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

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Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth / / **SSN** ◯ Disabled Dependent

Relationship

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Please select the type of information we can release to your child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information