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CONFIDENTIAL

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** ______

Section 2: Additional Dependent(s) Information

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other______

Last Name (if different) ______ Title ______ **First Name** ______ MI ______ **Social Security Number** ______

Gender:
☐Female ☐Male ☐Gender X **Birthdate** ______ , ______ , ______

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____
If yes, please provide name of college/university ______
Expected Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

______
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 ☐Adult Disabled Dependent (Separate application form required) ☐Other______

Last Name (if different) ______ Title ______ **First Name** ______ MI ______ **Social Security Number** ______

Gender:
☐Female ☐Male ☐Gender X **Birthdate** ______ , ______ , ______

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes
If yes, please provide name of college/university ______
Expected Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

______
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 ☐Adult Disabled Dependent (Separate application form required) ☐Other______

Last Name (if different) ______ Title ______ **First Name** ______ MI ______ **Social Security Number** ______

Gender:
☐Female ☐Male ☐Gender X **Birthdate** ______ , ______ , ______

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____
If yes, please provide name of college/university ______
Expected Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

______
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** ______