DEPENDENT ATTACHMENT FORM

EMPLOYEE INFORMATION

SSN or Member ID # ________________________________

Employee's Name	**First Name**	**MI**	**Last Name**
Please Print			

ADD **DROP**

CHILD: ☐ ☐ Health — Name: ______________________ SSN: ______________________
☐ ☐ Dental — Date of Birth: ______________ Date of Death: ______________ ☐ Male ☐ Female
☐ ☐ Vision — Primary Physician: ______________________ ☐ Current Patient ☐ New Patient
☐ ☐ Dependent Life — Primary Dentist: ______________________ ☐ Current Patient ☐ New Patient

ADD **DROP**

CHILD: ☐ ☐ Health — Name: ______________________ SSN: ______________________
☐ ☐ Dental — Date of Birth: ______________ Date of Death: ______________ ☐ Male ☐ Female
☐ ☐ Vision — Primary Physician: ______________________ ☐ Current Patient ☐ New Patient
☐ ☐ Dependent Life — Primary Dentist: ______________________ ☐ Current Patient ☐ New Patient

ADD **DROP**

CHILD: ☐ ☐ Health — Name: ______________________ SSN: ______________________
☐ ☐ Dental — Date of Birth: ______________ Date of Death: ______________ ☐ Male ☐ Female
☐ ☐ Vision — Primary Physician: ______________________ ☐ Current Patient ☐ New Patient
☐ ☐ Dependent Life — Primary Dentist: ______________________ ☐ Current Patient ☐ New Patient

ADD **DROP**

CHILD: ☐ ☐ Health — Name: ______________________ SSN: ______________________
☐ ☐ Dental — Date of Birth: ______________ Date of Death: ______________ ☐ Male ☐ Female
☐ ☐ Vision — Primary Physician: ______________________ ☐ Current Patient ☐ New Patient
☐ ☐ Dependent Life — Primary Dentist: ______________________ ☐ Current Patient ☐ New Patient

ADD **DROP**

CHILD: ☐ ☐ Health — Name: ______________________ SSN: ______________________
☐ ☐ Dental — Date of Birth: ______________ Date of Death: ______________ ☐ Male ☐ Female
☐ ☐ Vision — Primary Physician: ______________________ ☐ Current Patient ☐ New Patient
☐ ☐ Dependent Life — Primary Dentist: ______________________ ☐ Current Patient ☐ New Patient