PLEASE COMPLETE REGARDING ADULT DEPENDENTS:

CHILDREN AGES 19-26 YRS (REGARDLESS OF FULL TIME STUDENT STATUS)

Adult Dependent Child's Information

Last Name:		First Name:	Middle Int:
Home Address:	City:		State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: **YES** **NO**		Are you currently married?: **YES** **NO**	
Do you have other insurance coverage **available** through your own employer or your spouse's employer?: **YES** **NO**			
Have you elected this coverage?: **YES** **NO**			

Type of Coverage: Medical _____Dental _____ Rx _____

Name of Plan: _____ Effective Date: _____

Name of Subscriber:_____Relationship: _____

Phone Number: _____ Termination Date: _____

Adult Dependent Child's Information

Last Name:		First Name:	Middle Int:
Home Address:	City:		State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: **YES** **NO**		Are you currently married?: **YES** **NO**	
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Have you elected this coverage?: **YES** **NO**			

Type of Coverage: Medical _____Dental _____ Rx _____

Name of Plan: _____ Effective Date: _____

Name of Subscriber:_____Relationship: _____

Phone Number: _____ Termination Date: _____

Please submit copies of other insurance cards if applicable.