



**DEPENDENT CHILD NO. 2**

Name: \_\_\_\_\_ Gender: M F

Last First MI

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_  
Month Day Year

Coverage enrolled for: Medical \_\_\_ Dental \_\_\_ Vision \_\_\_  
Relationship to You: Natural-born or legally adopted \_\_\_ Stepchild \_\_\_ Legal Guardian \_\_\_

Complete the following only if Dependent Child is between ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes \_\_\_ No \_\_\_

If Yes: Name of School \_\_\_\_\_

Number of Credit Hours for Current Semester/Quarter \_\_\_\_\_

Is Student Covered by Any Other Group Health Insurance? Yes \_\_\_ No \_\_\_

If yes, Name of Carrier \_\_\_\_\_ Policy or Certificate No. \_\_\_\_\_

Address \_\_\_\_\_

**DEPENDENT CHILD NO. 3**

Name: \_\_\_\_\_ Gender: M F

Last First MI

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_  
Month Day Year

Coverage enrolled for: Medical \_\_\_ Dental \_\_\_ Vision \_\_\_  
Relationship to You: Natural-born or legally adopted \_\_\_ Stepchild \_\_\_ Legal Guardian \_\_\_

Complete the following only if Dependent Child is between ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes \_\_\_ No \_\_\_

If Yes: Name of School \_\_\_\_\_

Number of Credit Hours for Current Semester/Quarter \_\_\_\_\_

Is Student Covered by Any Other Group Health Insurance? Yes \_\_\_ No \_\_\_

If yes, Name of Carrier \_\_\_\_\_ Policy or Certificate No. \_\_\_\_\_

Address \_\_\_\_\_

**DEPENDENT CHILD NO. 4**

Name: \_\_\_\_\_ Gender: M F

Last First MI

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_  
Month Day Year

Coverage enrolled for: Medical \_\_\_ Dental \_\_\_ Vision \_\_\_  
Relationship to You: Natural-born or legally adopted \_\_\_ Stepchild \_\_\_ Legal Guardian \_\_\_

Complete the following only if Dependent Child is between ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes \_\_\_ No \_\_\_

If Yes: Name of School \_\_\_\_\_

Number of Credit Hours for Current Semester/Quarter \_\_\_\_\_

Is Student Covered by Any Other Group Health Insurance? Yes \_\_\_ No \_\_\_

If yes, Name of Carrier \_\_\_\_\_ Policy or Certificate No. \_\_\_\_\_

Address \_\_\_\_\_

Additional Medical, Dental and Vision Care Insurance Dependent Information Request Forms are available from your Campus Benefits Office.