Unit Name: _____
Member SSN: _____
Dependent ____ of ____

Department of Central Management Services
Local Government Health Plan
DEPENDENT ENROLLMENT FORM

DEPENDENT BIOGRAPHICAL (Please print or type)
Dependent SSN: _____ Effective Date of Add: _____
Temporary SSN (Y/N) _____

Name: _____ _____ _____
(Name as it appears on SS card) Last First Middle

Birthdate: _____ Sex (F/M) _____ Retirement Date: _____

Medicare Status Code: _____ Part A Begin Date: _____ Free Part A (Y/N) _____

Part B Begin Date: _____ Part D Begin Date: _____

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (other than member's)

_____

_____

City/State: _____
Resident County: _____
Zip: _____
Send Mail to this Address (Y/N) _____

Dependent Other Addressee (guardian, etc.)

_____

_____

City/State: _____
Resident County: _____
Zip: _____
Addressee SSN: _____
Relationship: _____
Date of Relationship: _____
Send Mail to this Address (Y/N) _____

TYPE DEPENDENT
Relationship Code: _____

Please Check Box: ☐ (10) Dep. Of Active Member
☐ (40) Dep. Of COBRA Member

Member must provide proof of dependent relationship. Please refer to the Health Plan Representative Manual for a list of acceptable documents. Dependents must be enrolled with the same health carrier as the Member.

Health PCP (If Applicable) _____ Pre-Existing Months Applied _____

COORDINATION OF BENEFITS – Other Group Health/Dental Insurance (Y/N) _____
(If yes, indicate below)

Plan	Begin Date	Carrier Name
Health	_____	_____
Dental	_____	_____

_____ _____
Member Signature Date HPR Signature Date