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XYZ Healthcare

Health Benefits Update Form

Section I – General Information

Full Name: KIMBERLEY (Last) MELISSA (First) (M.I.) Date: 07/31/2018

Address: 767 WINSON TREE (Street Address) 247 (Apartment/Unit #)

JERSEY CITY (City) NJ (State) 07310 (ZIP Code)

Phone: 317 421 9970 Email KM04@GMAIL.COM

Date of Birth (MM/DD/YYYY): 04/14/1981

Birth Sex M ☐ F ☒ Self-identified Gender M ☐ F ☒

Section II – Insurance Information

Insurance ID: 17476 Group Code: JXKM

Start Date: 01/01/2018 End Date: 12/31/2018 Coverage Type Enhanced ☒ Basic ☐

Section III – Dependent Information

Dependent Name: LYNN (Last) BOB (First) (M.I.) Date of Birth: 01/21/1984

Birth Sex M ☒ F ☐ Self-identified Gender M ☒ F ☐

Phone: 417 382 7417 Email BLYNN@YAHOO.COM

Section IV – Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

I declare that the foregoing is true and accurate to the best of my knowledge. I understand that any false, fictitious or fraudulent statement or representation, made knowingly will lead to termination of benefits.

Signature: [signature] Date: 07/31/2018