

Health Benefits Update Form

Section I – General Information

Full Name: DICKERSON JOHN Date: 2/3/17
Last First M.I.

Address: 657 GAYLE LN 212
Street Address Apartment/Unit #

PITTSBURGH PA 15112
City State ZIP Code

Phone: 412-572-2134 Email: johnndick@yahoo.com

Date of Birth (MM/DD/YYYY): 5/5/1972

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

Section II – Insurance Information

Insurance ID: 641247 Group Code: 444B

Start Date: 1/1/18 End Date: _____ Coverage Type ☐ Enhanced ☒ Basic

Section III – Dependent Information

Dependent Name: DICKERSON LAUREN J Date of Birth: 1/2/1988
Last First M.I.

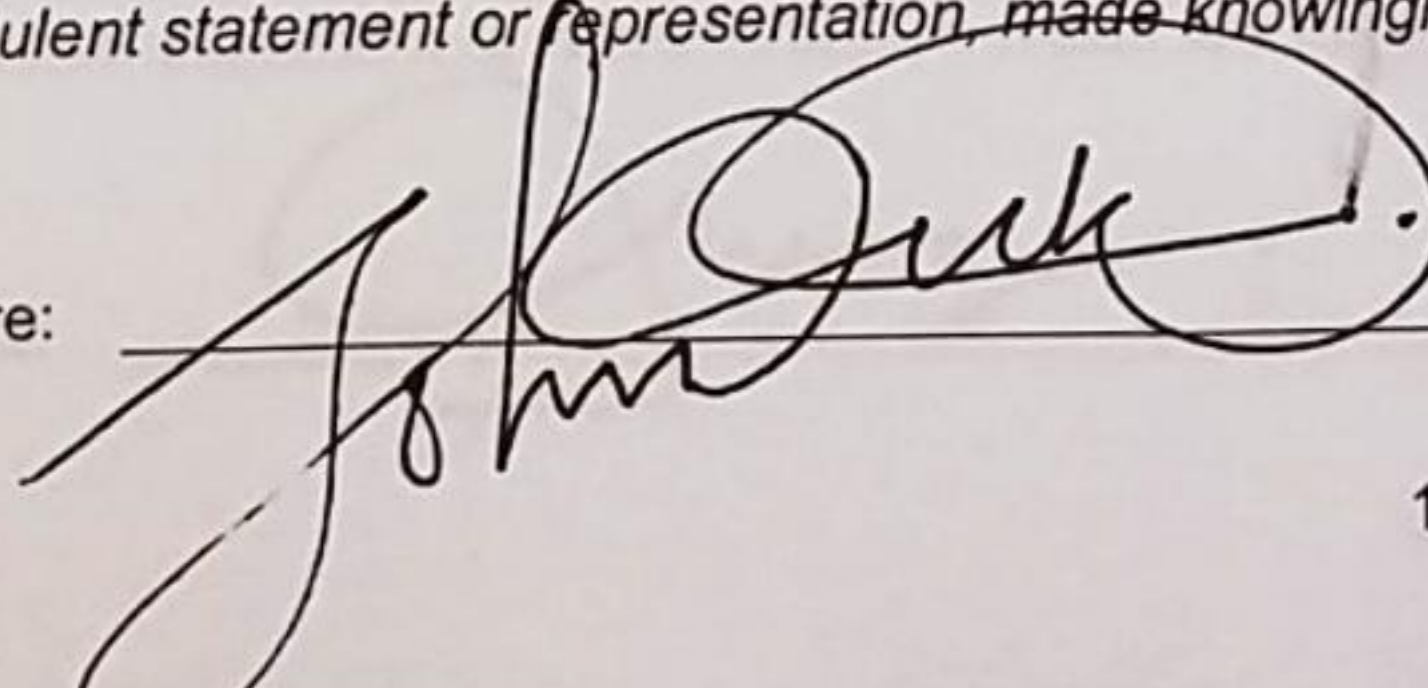
Birth Sex ☐ M ☒ F Self-identified Gender ☐ M ☒ F

Phone: 412-572-2133 Email: laurendick@gmail.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:  Date: 2/3/17