Please tell us about each person to be covered under this plan.

Primary applicant information

First Name, MI, Last Name (Full legal name)	Gender M/F	Relationship Code (See Codes Below)	Date of Birth (mm/dd/yyyy)	Social Security Number xxx-xx-xxxx	Marital Status M/S	Tobacco Use* (over last six months)	Are you currently enrolled in Medicare?
						☐Y ☐N	☐Y ☐N

Dependent information (spouse and other family members under age 26 unless permanently disabled)

First Name, MI, Last Name (Full legal name)	Gender M/F	Relationship Code (See Codes Below)	Date of Birth** (mm/dd/yyyy)	Social Security Number xxx-xx-xxxx	Marital Status M/S	Tobacco Use* (over last six months)	Are you currently enrolled in Medicare?
						☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N

*Applies to any applicant over the age of 18 who uses tobacco products regularly (four or more times per week), excluding those for religious or ceremonial use. If yes, please explain:

Relationship codes:

M - Subscriber
W – Wife
H - Husband
S - Son (dependent)
D - Daughter (dependent)
HD - Permanently disabled (dependent)

**A permanently disabled child of the applicant (or applicant's spouse) can be enrolled even if over the age of 26. However, the permanently disabled child over the age of 26 cannot be married. He or she must have been permanently disabled before reaching the age of 26 and must rely upon the applicant (or applicant's spouse) for more than half of their support. We require proof of permanent disability within 31 days of enrollment.

Primary applicant's information. (Please provide ALL information. P.O. boxes not accepted.)

Street address: _____ Apt. #: _____

City: _____ State: _____ ZIP code: _____ County: _____

Home phone number: _____ Cell phone: _____

Email address:_____

The primary applicant, along with their spouse and any dependents identified above are all considered applicants for purposes of this application.