Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No