BlueCross BlueShield of North Carolina

Additional Dependent Form

Completed By Group Administrator Only
Group Number (if applicable):
Blue Cross NC Subscriber ID Number (if applicable):

Instructions:

- Employees with more than 3 children enrolling on the plan should complete Sections **A** and **B**.

Please type or print in black or blue, NOT RED ink

A. EMPLOYEE INFORMATION

First Name:	Middle Initial:	Last Name:	Suffix:

Employee Birthdate: mm dd yyyy

Employee Social Security Number:

Company Name:

B. Additional Dependent Information [– Legal Documentation May be Required]

Health	Dental	Blue 20/20 Vision℠	Name (First, Middle Initial, Last, Suffix)	Social Security Number	[Phone Number]	Birthdate (mm/dd/yyyy)	Gender	Child Status (please check if applicable)
[☐ Y ☐ N]	[☐ Y ☐ N]	[☐ Y ☐ N]	Child 4				☐ M ☐ F	[☐ Intellectually or physically disabled]
[☐ Y ☐ N]	[☐ Y ☐ N]	[☐ Y ☐ N]	Child 5				☐ M ☐ F	[☐ Intellectually or physically disabled]
[☐ Y ☐ N]	[☐ Y ☐ N]	[☐ Y ☐ N]	Child 6				☐ M ☐ F	[☐ Intellectually or physically disabled]