



**LIST ALL DEPENDENTS TO BE COVERED:**

LAWFUL SPOUSE/DOMESTIC PARTNER OF EMPLOYEE AND EMPLOYEE'S CHILDREN UNDER 19 (OR UNDER AGE 25 IF FULL-TIME STUDENT) ATTACH NECESSARY DOCUMENTATION AS DESCRIBED BELOW. Eligible dependents listed below.

**Date of Marriage/Domestic Partner Registration:** \_\_\_\_\_  
Month Day Year

Relationship *	Last Name, First Name	Gender	Date of Birth	Social Security #

\* **Indicate Relationship:** 1) spouse, 2) domestic partner, 3) child, 4) step child, 5) adopted child, 6) foster child, 7) child of domestic partner, 8) child by legal guardianship.

**Attach the following required documentation if applicable:**

- Copy of Marriage Certificate or Domestic Partner Registration on file with County/State.
- Copy of Birth Certificate(s) for children.
- Copy of final Court Documents for adopted/foster children or divorce decree.
- If full time student over age 19 attach Certificate of Student Status from an accredited college or university (this will be required for every quarter or semester of enrollment for continued coverage).

**INFORMATION ON OTHER PLAN COVERAGE:**

**Do your spouse/domestic partner or dependent children currently have access to other group coverage?**  
\_\_\_\_\_ Yes                      \_\_\_\_\_ No

**If yes, Name & Address of Employer providing coverage:** \_\_\_\_\_  
\_\_\_\_\_

**If yes, have your spouse/domestic partner or dependent children elected not to be covered by this other plan?**  
\_\_\_\_\_ Yes                      \_\_\_\_\_ No

**Effective Date of Coverage:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Dependents Covered:** \_\_\_\_\_  
\_\_\_\_\_