

Employee Enrollment for Additional Dependents

Employee Name

Last Name	First Name	MI	Sex	Relationship	Birthdate	Height	Weight	Full Time Student	*Physician (First and Last Name)
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
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			M F					<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health information for dependents listed on this addendum, if required for enrollment, has been included in section G (Medical History) of this application.

Date	Employee Signature	Spouse Signature (if possible and applicable)