MEMPHIS Plan DEPENDENT Information

Name of Employer:_____ **Employee** _____

DEPENDENT Information ONLY

Name:_____Sex: Male_____ Female_____
First M.I. Last

Relation: spouse/daughter/son (circle one) SSN:_____ Birthdate:_____/_____/_____
month day year

Yes ___ No ___ **Do you have third party health insurance?** If yes, please attach a copy of your insurance ID card.

Yes ___ No ___ Have you been diagnosed with any of the following conditions (check all that apply):
☐ multiple sclerosis ☐ systemic lupus ☐ HIV/AIDS
☐ hepatitis C ☐ ALS (Lou Gehrig's Disease) ☐ cancer ☐ other:_____

Comments:_____

Yes ___ No ___ Have you been hospitalized for heart disease, lung disease, or kidney disease within the last year?
If Yes, please explain _____

Yes ___ No ___ Are you currently in treatment by a doctor or dentist (or has treatment been recommended) for any illness or dental condition? If Yes, please explain. _____

Yes ___ No ___ Have you been hospitalized or had surgery in the past two years? If Yes, please explain. _____

_____

Name:_____Sex: Male _____Female_____
First M.I. Last

Relation: spouse/daughter/son (circle one) SSN:_____ Birthdate:_____/_____/_____
month day year

Yes ___ No ___ **Do you have third party health insurance?** If yes, please attach a copy of your insurance ID card.

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☐ multiple sclerosis ☐ systemic lupus ☐ HIV/AIDS
☐ hepatitis C ☐ ALS (Lou Gehrig's Disease) ☐ cancer ☐ other:_____

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Yes ___ No ___ Have you been hospitalized or had surgery in the past two years? If Yes, please explain. _____

_____

Employee Signature _____ Date_____

Employer Signature _____Phone _____ Date _____

MEMPHIS Plan Signature _____ Date _____ Effective Date of Coverage _____