TICUA
BENEFIT CONSORTIUM

Additional Dependents

Complete this form and attach to enrollment or change form to list additional dependents

Section I: Employee Information

Employees, please fill out this page and return to your human resources department.

Last Name	First Name	MI	Social Security No.	Phone Number
			- -	( )

Section II (continued from Enrollment form): Enroll Additional Dependents

Please list all dependents that you want covered under the TICUA Benefit Consortium Health Care Plan for whom you did not have room on the Enrollment form

Name	Gender	Birthdate	SSN	Relationship (Spouse, son, daughter, etc.)	If Dependent was covered under a prior plan, list **original effective date of coverage.**
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					
Last Name, First Name M.I.					

Change form, Section B (continued): Add/Drop Dependents (if dropping all dependents, listing below is not necessary)

Add/Drop (Circle One)	Name	Gender	Birthdate	SSN	Relationship (Spouse, son, step-child, etc.)	Reason for Add/Drop* (See Codes on Change form)
A D	Last Name, First Name M.I.					
A D	Last Name, First Name M.I.					
A D	Last Name, First Name M.I.					
A D	Last Name, First Name M.I.					
A D	Last Name, First Name M.I.					
A D	Last Name, First Name M.I.					

Employee's Signature		Date Signed	