univera HEALTHCARE

CONFIDENTIAL

Additional Dependent Addendum

This form must be attached to a completed enrollment application/change form. Please print clearly. Signature is required.
For each additional dependent only complete fields below the dotted line if applicable to the product you are enrolling in.

Section 1: Subscriber's Information

Group # ____ **Subscriber's Last Name** ____ **First Name** ____ **MI** ____ **SSN** ____

Section 2: Additional Dependent(s) Information

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other____________

Last Name (if different) ____ Title ____ **First Name** ____ MI ____ **Social Security Number** ____

Gender:
☐Female ☐Male ☐Gender X **Birthdate** _______ , _______ , ___________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected
If yes, please provide name of college/university ______________ Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________ Part A Effective Date: ____ , ____ , _____ Part B Effective Date: ____ , ____ , _____
Medicare Number (if applicable)

Primary Care Physician's Last Name ____ First Name ____ Zip Code ____ Ob/Gyn's Last Name ____ First Name ____ Zip Code ____

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other____________

Last Name (if different) ____ Title ____ **First Name** ____ MI ____ **Social Security Number** ____

Gender:
☐Female ☐Male ☐Gender X **Birthdate** _______ , _______ , ___________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes Expected
If yes, please provide name of college/university ______________ Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________ Part A Effective Date: ____ , ____ , _____ Part B Effective Date: ____ , ____ , _____
Medicare Number (if applicable)

Primary Care Physician's Last Name ____ First Name ____ Zip Code ____ Ob/Gyn's Last Name ____ First Name ____ Zip Code ____

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other____________

Last Name (if different) ____ Title ____ **First Name** ____ MI ____ **Social Security Number** ____

Gender:
☐Female ☐Male ☐Gender X **Birthdate** _______ , _______ , ___________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Is dependent a full time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected
If yes, please provide name of college/university ______________ Graduation Date: ___ , ___ , ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________ Part A Effective Date: ____ , ____ , _____ Part B Effective Date: ____ , ____ , _____
Medicare Number (if applicable)

Primary Care Physician's Last Name ____ First Name ____ Zip Code ____ Ob/Gyn's Last Name ____ First Name ____ Zip Code ____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature ______________________ **Date** ____________