Additional Dependent Form

Completed by Group Administrator Only
Group Number (if applicable):
Life Class Designation (if applicable):

Instructions:

- Employees with more than 3 children enrolling on the plan should complete Sections **A** and **B**.

Please type or print in black or blue, NOT RED ink

A. Employee Information

First Name	Middle Initial	Last Name	Suffix

Employee Birthdate (mm / dd / yyyy)	Employee Social Security Number	☐ Male ☐ Female	Marital Status

Company Name

B. Additional Dependent Information – Legal Documentation May be Required

Health	Dental	Blue 20/20 Vision℠	Name First, Middle Initial, Last, Suffix	Social Security Number	Phone Number	Birthdate mm/dd/yyyy	Gender	Child Status (please check if applicable for any dependent under the age of 26)
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 4**				☐ M ☐ F	☐ Handicapped
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 5**				☐ M ☐ F	☐ Handicapped
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 6**				☐ M ☐ F	☐ Handicapped

An independent licensee of the Blue Cross and Blue Shield Association. ®, SM Marks of the Blue Cross and Blue Shield Association.

Visit us at ***BlueCrossNC.com***

GRPADD, 4/18