MEMPHIS Plan DEPENDENT Information

Employer/Self Employed/MP Direct:______________________________**Participant**__________________________________

DEPENDENT Information ONLY

Name:____Gender: Male ☐ Female ☐
First M.I. Last

Relation: ☐spouse ☐daughter ☐ son ☐other SSN:________________________ Birthdate: _________________________
(select one) month day year

Yes ☐ No ☐ **Do you have third party health insurance?**

Yes ☐ No ☐ **In treatment or treatment recommended by a doctor or dentist for any illness or dental condition?**

If Yes, please explain ____

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 (please explain)____
____

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First M.I. Last

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____

Participant Signature ____ Date_______________

Employer Signature ____Phone:_______________ Date _______________