DEPENDENT ATTACHMENT FORM

EMPLOYEE INFORMATION SSN or Member ID # MI Employee's Name First Name **Last Name** Please Print ADD DROP CHILD: □ _____ SSN: ____ Health Date of Birth: Date of Death: Male Female Dental Primary Physician: Current Patient New Patient Vision Dependent Life Primary Dentist: _____ Current Patient New Patient ADD DROP CHILD: □ Name: ______ SSN: ____ Health Date of Birth: Date of Death: Male Female Dental Vision Primary Physician: _____ Current Patient New Patient Dependent Life Primary Dentist: _____ Current Patient New Patient ADD DROP Name: ______ SSN: ____ CHILD: □ Health Date of Birth: _____ Date of Death: ____ Male Female Dental Primary Physician: Current Patient Vision New Patient Dependent Life Primary Dentist: _____ Current Patient New Patient ADD DROP _____ SSN: ____ CHILD: □ Health Date of Birth: Date of Death: Male Female Dental Primary Physician: _____ Current Patient Vision New Patient Dependent Life Primary Dentist: _____ Current Patient New Patient ADD DROP Name: ______ SSN: _____ CHILD: □ Health Dental Primary Physician: _____ Current Patient Vision New Patient Dependent Life Primary Dentist: New Patient