3. APPLICANT AND SPOUSE/DEPENDENT INFORMATION (continued)

Applicant (cont.)

Home Phone | Daytime Phone

Home Address

Apt. No. | City | State | Zip

Occupation | Primary Language

PCP Last Name | PCP First Name | PCP Number | Current Patient of PCP? ◯ Y ◯ N

Primary Care Dentist (PCD) Last Name | PCD First Name | PCD Number | Current Patient of PCD? ◯ Y ◯ N

Spouse

Social Security Number | Birth Date (MMDDYY) | Gender ◯ M ◯ F | Primary Language (if different)

Last Name (if different) | First Name | MI

PCP Last Name | PCP First Name | PCP No. | Current Patient of PCP? ◯ Y ◯ N

Dependent 1

Social Security Number | Birth Date (MMDDYY) | Gender ◯ M ◯ F | Primary Language (if different)

Last Name (if different) | First Name | MI

PCP Last Name | PCP First Name | PCP No. | Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

Dependent 2

Social Security Number | Birth Date (MMDDYY) | Gender ◯ M ◯ F | Primary Language (if different)

Last Name (if different) | First Name | MI

PCP Last Name | PCP First Name | PCP No. | Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

Dependent 3

Social Security Number | Birth Date (MMDDYY) | Gender ◯ M ◯ F | Primary Language (if different)

Last Name (if different) | First Name | MI

PCP Last Name | PCP First Name | PCP No. | Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

¥ Must be age 19+ and attend accredited college or university. Submit proof with this form. Proof is required annually.

§ Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.