

Dependent Addition

This letter is to request the addition of my dependent(s) to my current coverage with Bethany Benefit Service. I and my employer agree to the change in premium rate if I do not already have family health insurance coverage.	Instructions: Fill out and return this form to Bethany Benefit	Service.		
Name:		•	•	
Effective Date of Change: / / Check one: Full health coverage Dental/vision only 2.DEFENDENT INFORMATION Please note: children through age 25 are eligible. Legal documentation must be included for adoptions. Spouse name: Alle Female Date of birth: / / / SSN: Child name: / / / SSN: Sate of birth: / / / SSN: Sate of birth: / / /	1. YOUR INFORMATION			
Check one: Full health coverage Dental/vision only 2.DEFENDENT INFORMATION Please note: children through age 25 are eligible. Legal documentation must be included for adoptions. Spouse name:	Name:	SSN:		
Dental/vision only Dental/vision only Please note: children through age 25 are eligible. Legal documentation must be included for adoptions. Spouse name:	Effective Date of Change://			
Please note: children through age 25 are eligible. Legal documentation must be included for adoptions. Spouse name:	e			
Spouse name:	2. DEPENDENT INFORMATION			
Date of birth: / / SSN:	Please note: children through age 25 are eligible. Legal document	ation must be include	d for adoptions.	
Child name: / / / SSN:	Spouse name:		_ 🗌 Male	Female
Date of birth: / / SSN:	Date of birth: / /	SSN:		
Child name:	Child name:		_ 🗌 Male	□ Female
Date of birth: / / SSN:	Date of birth: / /	SSN:		
Child name:	Child name:		_ 🗌 Male	Female
Date of birth: // SSN: Child name: Child name: Date of birth: // Date of birth: / SSN: 3. AUTHORIZED SIGNATURES This form, signed by the policyholder and an authorized representative of the employer (treasurer, business manger, etc.), is to request the addition of dependents for the indicated policyholder as stated above. Signature: Date:/	Date of birth: /	SSN:		
Child name: Image: Date of birth: // SSN: Image: 3. AUTHORIZED SIGNATURES This form, signed by the policyholder and an authorized representative of the employer (treasurer, business manger, etc.), is to request the addition of dependents for the indicated policyholder as stated above. Signature: Image: Date: Image: <	Child name:		_ 🗌 Male	Female
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Traccurer/Businesss		-	•	business manger, etc.),
Treasurer/Businesss Manager Signature: Date: //	Signature:		Date:	//
	Treasurer/Businesss Manager Signature:		Date:	//