COVENANT BENEFITS

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Dependent Addition

Instructions: Fill out and return this form to Covenant Benefits.

I request the addition of my dependent(s) to my current coverage with Covenant Benefits. I and my employer agree to the change in premium rate if I do not already have family health insurance coverage.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ / _____ / _____

Check all that apply:
- ☐ Medical/prescription
- ☐ Dental/vision

2. DEPENDENT INFORMATION

Please note: Legal documentation of marriage, birth or adoption may be requested.

Spouse name: _____ ☐ Male ☐ Female

Date of birth: _____ / _____ / _____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ / _____ / _____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ / _____ / _____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ / _____ / _____ SSN: _____

Child name: _____ ☐ Male ☐ Female

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: _____ / _____ / _____

Treasurer/Businesss Manager Signature: _____ Date: _____ / _____ / _____