State of Illinois
Department of Central Management Services

LOCAL GOVERNMENT HEALTH PLAN
Dependent Enrollment Form

Unit Name: ______________________ Member SSN: __________ Dependent ____ of ____

DEPENDENT BIOGRAPHICAL INFORMATION (Please Print or Type)

Dependent SSN: __________ Temporary SSN: ☐ Yes ☐ No Eff. Date of Add: __________

Name *(As it appears on SS Card)*

Last: __________ First: __________ Middle: __________

Birthdate: __________ Sex: ☐ Male ☐ Female

Medicare Status Code: ______ Part A (begin date) __________ Part A Free ☐ Yes ☐ No

Part B (begin date) __________ Part D (begin date) __________

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (other than member's)

City/State: __________

ZIP Code: ______ County: __________

Send Mail to this Address? ☐ Yes ☐ No

Dependent Other Addressee (guardian, etc.)

City/State: __________

ZIP Code: ______ County: __________

Addressee SSN: __________

Relationship: __________

Date of Relationship: __________

Send Mail to this Address? ☐ Yes ☐ No

TYPE DEPENDENT

Relationship Code: ______ Check Appropriate Box: ☐ (10) Dependent of Active Member
☐ (40) Dependent of COBRA Member

Member must provide proof of dependent relationship. Please refer to the Health Plan Representative Manual for a list of acceptable documents. Dependents must be enrolled with the same health carrier as the Member.

Health NPI# (if applicable): __________ Medical Group/IPA# (if applicable): ______

Member Signature: ______________________ Date: __________

I have reviewed and explained all options available to the above member.

Health Plan Representative Signature: ______________________ Date: __________

Health Plan Representative Phone Number: __________