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: _____