BlueCross BlueShield of North Carolina

# Additional Dependent Form

| Completed By Group Administrator Only |
|---|
| Group Number (if applicable): |
| Blue Cross NC Subscriber ID Number (if applicable): |

**Instructions:**

- Employees with more than 3 children enrolling on the plan should complete Sections **A** and **B**.

**Please type or print in black or blue, NOT RED ink**

## A. EMPLOYEE INFORMATION

| First Name: | Middle Initial: | Last Name: | Suffix: |
|---|---|---|---|
| | | | |

Employee Birthdate: mm dd yyyy

Employee Social Security Number:

Company Name:

## B. Additional Dependent Information – Legal Documentation May be Required

| Health | Dental | Blue 20/20 Vision℠ | Name (First, Middle Initial, Last, Suffix) | Social Security Number | Phone Number | Birthdate (mm/dd/yyyy) | Gender | Child Status (please check if applicable) |
|---|---|---|---|---|---|---|---|---|
| ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | Child 4 | | | | ☐ M ☐ F | ☐ Intellectually or physically disabled |
| ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | Child 5 | | | | ☐ M ☐ F | ☐ Intellectually or physically disabled |
| ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N | Child 6 | | | | ☐ M ☐ F | ☐ Intellectually or physically disabled |
| | | | | | | | | |