|  |
| --- |
| Dependent Child |
| Coverage Status | Child of | Tobacco Use | Race |
| [ ] Enroll[ ] Remove | [ ] Mine/Spouse[ ] Domestic Partner | [ ] No[ ] Yes | [ ] Asian[ ] Hispanic/Latino[ ] White/Caucasian | [ ] Black/African American [ ] American Indian/Alaska Native[ ] Native Hawaiian/Pacific Islander  |
| Social Security Number | Last Name | First Name | Birth Date | Gender |
|       |       |       |       |       |
| Address (if different than member) | City | State | Zip |
|       |       |    |       |
| Medical Primary Care Provider Name & Address (for SmartChoice enrollment only) |
|            |
|  |
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