

Group Number

Social Security Number

Humana Dependent Information Form

Please print clearly and fill in each applicable circle.

1. Last name First name MI Date of birth

Social Security number Gender: Female Male Relationship: Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current Patient: No Yes

DHMO: (applicable to AZ, CA, FL, IL, and TX only)

Primary dentist Facility number Current Patient: No Yes

2. Last name First name MI Date of birth

Social Security number Gender: Female Male Relationship: Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current Patient: No Yes

DHMO: (applicable to AZ, CA, FL, IL, and TX only)

Primary dentist Facility number Current Patient: No Yes

3. Last name First name MI Date of birth

Social Security number Gender: Female Male Relationship: Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current Patient: No Yes

DHMO: (applicable to AZ, CA, FL, IL, and TX only)

Primary dentist Facility number Current Patient: No Yes

4. Last name First name MI Date of birth

Social Security number Gender: Female Male Relationship: Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current Patient: No Yes

DHMO: (applicable to AZ, CA, FL, IL, and TX only)

Primary dentist Facility number Current Patient: No Yes

5. Last name First name MI Date of birth

Social Security number Gender: Female Male Relationship: Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current Patient: No Yes

DHMO: (applicable to AZ, CA, FL, IL, and TX only)

Primary dentist Facility number Current Patient: No Yes