# Humana Dependent Information Form

**Please print clearly.**

Group number

Employee Social Security number

1. Last name | First name | MI

Social security number | Date of birth (MMDDYYYY) | Relationship: ◯ Spouse ◯ Child ◯ Other: _____

Gender: ◯ Female ◯ Male  Dependent status (if applicable): ◯ Disabled ◯ Full-time student  If disabled, indicate reason: _____

**HMO and POS only:**

Primary care physician | Physician ID | Current patient? ◯ No ◯ Yes

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

Primary dentist | Facility number | Current patient? ◯ No ◯ Yes

2. Last name | First name | MI

Social security number | Date of birth (MMDDYYYY) | Relationship: ◯ Spouse ◯ Child ◯ Other: _____

Gender: ◯ Female ◯ Male  Dependent status (if applicable): ◯ Disabled ◯ Full-time student  If disabled, indicate reason: _____

**HMO and POS only:**

Primary care physician | Physician ID | Current patient? ◯ No ◯ Yes

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

Primary dentist | Facility number | Current patient? ◯ No ◯ Yes

3. Last name | First name | MI

Social security number | Date of birth (MMDDYYYY) | Relationship: ◯ Spouse ◯ Child ◯ Other: _____

Gender: ◯ Female ◯ Male  Dependent status (if applicable): ◯ Disabled ◯ Full-time student  If disabled, indicate reason: _____

**HMO and POS only:**

Primary care physician | Physician ID | Current patient? ◯ No ◯ Yes

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

Primary dentist | Facility number | Current patient? ◯ No ◯ Yes

4. Last name | First name | MI

Social security number | Date of birth (MMDDYYYY) | Relationship: ◯ Spouse ◯ Child ◯ Other: _____

Gender: ◯ Female ◯ Male  Dependent status (if applicable): ◯ Disabled ◯ Full-time student  If disabled, indicate reason: _____

**HMO and POS only:**

Primary care physician | Physician ID | Current patient? ◯ No ◯ Yes

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

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