

Employee & Dependent Information						
<p style="text-align: center;">If electing level of coverage that includes spouse/domestic partner or children, complete this section. If covering more than 3 dependent children, make a copy of side 2 of this form, complete additional dependent fields, and attach.</p>						
Employee	If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP			If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP		If electing the DHMO, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
Dependent 1	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCP		If electing the DHMO, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCD
Dependent 2	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCP		If electing the DHMO, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCD
Dependent 3	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCP		If electing the DHMO, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of this PCD
Employee Signature						
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties. I agree to comply with all provisions and procedures that govern administration of the Benefit Plans for Carnegie Mellon. I understand the university will make the necessary adjustment to my pay based on these changes/elections.						
Signature _____					Date _____	

Return to: Human Resources Benefits & Compensation Office, 5000 Forbes Avenue, Pittsburgh, PA 15213-3815

Questions? Contact 412-268-5077 or gayler@cmu.edu.