Patient Protection and Affordable Care Act
Newly Eligible Dependent Enrollment Form

ENROLLEE: Complete all areas. PLEASE PRINT CLEARLY.
If additional space is necessary, complete and attach additional forms.

ENROLLEE INFORMATION

FULL LEGAL NAME (Avoid nicknames and abbreviations) Include title (Jr., Sr., III, etc.)	Relationship	Gender (Circle)	Birth Date (mo-day-yr)	Enrollee ID Number
Enrollee Name (Last) (First) (MI)	SELF	M F		
Enrollee Address (Street, City, State, Zip Code)				

DEPENDENT INFORMATION

FULL LEGAL NAME (Avoid nicknames and abbreviations) Include title (Jr., Sr., III, etc.)	Relationship	Gender (Circle)	Birth Date (mo-day-yr)	Social Security Number
Dependent (Last-if different from Enrollee) (First) (MI)	DEP	M F		
Dependent Address-if different from Enrollee (Street, City, State, Zip Code)				
Dependent (Last-if different from Enrollee) (First) (MI)	DEP	M F		
Dependent Address-if different from Enrollee (Street, City, State, Zip Code)				
Dependent (Last-if different from Enrollee) (First) (MI)	DEP	M F		
Dependent Address-if different from Enrollee (Street, City, State, Zip Code)				

Have any of the above listed dependents **NOT** been previously covered under a MHBP plan? ☐Yes ☐No
If YES, then please attach to this form, a copy of the Dependent's birth certificate or other appropriate legal documentation supporting the relationship.

Is Dependent currently covered under another health care plan or Medicare? ☐Yes ☐No
If YES, please complete the following:

Name of Other Carrier or Medicare	Name of Subscriber on other Plan	Subscriber DOB	**Benefit Type(s) (circle)** Medical Dental Vision Rx
Actively Employed? ☐ Yes ☐ No	Retired? ☐ Yes Date: ☐ No	Effective Date of Covg.	Term Date (if applicable)

Please send completed form to:
MHBP Eligibility
P.O. Box 30088
Salt Lake City, UT 84130

Fax number: 801-954-3103