



HEALTH PLAN  
 APWU Health Plan  
 799 Cromwell Park Drive  
 Suites K-Z  
 Glen Burnie, MD 21061

Member ID # \_\_\_\_\_

**APPLICATION TO ADD DEPENDENT UP TO AGE 26**

(Please Print Clearly)

\_\_\_\_\_  
 Dependent Last Name                      Dependent First Name                      Dependent Middle Initial

\_\_\_\_\_  
 Dependent Date of Birth                      Dependent Social Security Number

**Dependent Address:**

\_\_\_\_\_

\_\_\_\_\_  
 City                      State                      Zip

What is your relationship to this child? – Please check the appropriate box:

Natural Born Child       Adopted Child       Step Child       Foster Child

*Please enclose a copy of your child's birth certificate if the child has a last name that is different than your last name.*

*If your dependent is a foster child, you must provide copies of the court documentation placing the child in your care.*

Does this child have other Medical Coverage? YES       NO

If you have answered YES, please complete the section below:

Name of Other Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

**Relationship to Policy Holder (Please check the appropriate box):**

Self  Spouse  Parent  Guardian

**Does this Child Have Other Dental Coverage? YES  NO**

**If you have answered YES, please complete the section below:**

**Name of Other Carrier:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Effective Date of Coverage:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_

**Relationship to Policy Holder (Please check the appropriate box):**

Self  Spouse  Parent  Guardian

**Is this a FEHBP Dental Plan? YES  NO**

**Does this Child Have other Prescription Coverage? YES  NO**

**If you have answered YES, please complete the section below:**

**Name of Other Carrier:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Effective Date of Coverage:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_

**Relationship to Policy Holder (Please check the appropriate box):**

Self  Spouse  Parent  Guardian

\_\_\_\_\_  
**Subscriber Signature**

\_\_\_\_\_  
**Date**

**Please COPY this Form for EACH Dependent you wish to add to your Self & Family Coverage.**

**Please return this completed application to:**

**APWU Health Plan  
799 Cromwell Park Drive, Suites K-Z  
Glen Burnie, MD 21061  
ATTN: ENROLLMENT UNIT**