## 2019 DEPENDENT INFORMATION

				· 	Indicate "YES" if Applicable		
			# of			- " <del>-</del> "	Healthcare
First, Middle Intial and Last Name	SSN	Relationship	Months in Home	Date of Birth	Disabled?	Full Time Student?	Coverage ALL Year?
i iist, iviidale iiital alia East Walle	0011	relationship	III I IOIIIC	Date of Birtin	Disablea:	Otadenti	ALL TOUT: