DEPENDENT 3: _____ MALE _____ FEMALE _____

RELATIONSHIP TO YOU (CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE (DEC 2015): _____

NUMBER OF MONTHS LIVED WITH YOU IN 2015? _____ IS THIS PERSON DIABLED (Y/N)? _____

DID YOU PAY DAYCARE (Y/N)? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE (Y/N)? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 4: _____ MALE _____ FEMALE _____

RELATIONSHIP TO YOU (CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE (DEC 2015): _____

NUMBER OF MONTHS LIVED WITH YOU IN 2015? _____ IS THIS PERSON DIABLED (Y/N)? _____

DID YOU PAY DAYCARE (Y/N)? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE (Y/N)? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 5: _____ MALE _____ FEMALE _____

RELATIONSHIP TO YOU (CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE (DEC 2015): _____

NUMBER OF MONTHS LIVED WITH YOU IN 2015? _____ IS THIS PERSON DISABLED (Y/N)? _____

DID YOU PAY DAYCARE (Y/N)? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE (Y/N)? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 6: _____ MALE _____ FEMALE _____

RELATIONSHIP TO YOU (CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE (DEC 2015): _____

NUMBER OF MONTHS LIVED WITH YOU IN 2015? _____ IS THIS PERSON DIABLED (Y/N)? _____

DID YOU PAY DAYCARE (Y/N)? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE (Y/N)? _____

NAME OF INSURANCE COMPANY: _____