DEPENDENT 3: _____ MALE _____ FEMALE _____

RELATIONSHIP (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2016? _____ IS THIS PERSON DIABLED? _____

DID YOU PAY DAYCARE? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 4: _____ MALE _____ FEMALE _____

RELATIONSHIP (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2016? _____ IS THIS PERSON DISABLED? _____

DID YOU PAY DAYCARE? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 5: _____ MALE _____ FEMALE _____

RELATIONSHIP (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2016? _____ IS THIS PERSON DISABLED? _____

DID YOU PAY DAYCARE? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE? _____

NAME OF INSURANCE COMPANY: _____

DEPENDENT 6: _____ MALE _____ FEMALE _____

RELATIONSHIP (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2016? _____ IS THIS PERSON DIABLED? _____

DID YOU PAY DAYCARE? _____ DOES THIS INDIVIDUAL HAVE HEALTH INSURANCE? _____

NAME OF INSURANCE COMPANY: _____