

INTEGRATED BENEFITS
ADMINISTRATION

Employee Dependent Information

Employer Name: _____ Effective Date: _____

Employee Name: _____ Social Security Number: _____

ADD Delete: (Please Check One)

<u>Social Security Number</u>	<u>NAME</u>	<u>D.O.B.</u>	<u>Gender</u>	<u>Relationship to You</u>

Are any of your dependents disabled? Yes No If so, whom? _____

Signature: _____

Today's Date: _____

Fax to:

INTEGRATED BENEFITS ADMINISTRATION
208-287-0311