DEPENDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Date of Birth (YYYY/MM/DD)	Gender	Height	Weight
Spouse					q ft/in q cm	q lbs q kg
Child					q ft/in q cm	q lbs q kg
Child					q ft/in q cm	q lbs q kg
Child					q ft/in q cm	q lbs q kg
Child					q ft/in q cm	q lbs q kg

DEPENDENT HEALTH QUESTIONNAIRE

IF YOU ANSWER "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS BELOW.

Question Number	Name	Nature of Disorder	Date of Onset (YYYY/MM/DD)	Date of Recovery (YYYY/MM/DD)	Medication and/or Treatment	Approximate Monthly Cost