



**DEPENDENT CHANGES**

**SPOUSE\***

Add Drop

Health Name \_\_\_\_\_ SSN \_\_\_\_\_  
  Dental Date of Birth \_\_\_\_\_  Male  Female  
  Vision Primary Physician \_\_\_\_\_  New Patient  Current Patient  
Primary Dentist \_\_\_\_\_  New Patient  Current Patient

\*Does your spouse currently have coverage through OMES EGID?  Yes  No (If yes, list name and SSN above)

**CHILD**

Add Drop

Health Name \_\_\_\_\_ SSN \_\_\_\_\_  
  Dental Date of Birth \_\_\_\_\_  Male  Female  
  Vision Primary Physician \_\_\_\_\_  New Patient  Current Patient  
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**CERTIFICATION SIGNATURES**

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**SPOUSE MUST SIGN IF COMMON-LAW.**

**COMMON-LAW SPOUSE CERTIFICATION:** I certify that the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship, and that our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware that this relationship can be dissolved only by legal divorce.**

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_