

# HEALTHY DOLLARS

## DEPENDENT CARD REQUEST

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Dependent Information: Please list all eligible dependents that require an additional card.**

Name: (Last, First MI)	Date of Birth	Relation to Employee	Social Security Number
1)			
2)			
3)			

Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_