

ART I: DOCUMENT IDENTIFICATION-REQUIRED INFORMATION.

405-34-0021 5-16-75 R.M. ROBERT M. HOGAN
 SOCIAL SECURITY NO. EFFECTIVE DATE FIRST NAME MIDDLE INIT. LAST NAME
 7800 Rochelle Rd. Louisville Mailing City
 Mailing Street Address Mailing State ZIP Code Kentucky 502 968-1664
 AREA CODE TELEPHONE NUMBER
 ENTER "Y" IF UNLISTED

ART II: TO BE COMPLETED WITH SPOUSE'S EMPLOYER INFORMATION.

8-1-71 J. Co. Bld. of Education Louisville
 DATE EMPLOYMENT BEGAN EMPLOYER NAME
 ARE YOU CHANGING EXISTING DATA ☒ OR ADDING NEW DATA ☒
 EMPLOYER CITY EMPLOYER STATE Kentucky
 MO. & YR. ENDED EMPLOYMENT

IS THE SPOUSE COVERED BY EMPLOYER BENEFITS? ☒ ENTER "Y" OR "N"
☒ HOSPITALIZATION ☒ MAJOR MEDICAL ☒ PRESCRIPTION DRUG ☒ HEALTH MAINT. ORG. (HMO) MEMBER
 DOES EMPLOYER'S HOSPITALIZATION/MEDICAL BENEFITS PROGRAM CONTAIN CO-ORDINATION OF BENEFITS PROVISIONS? ☒ ENTER "Y" OR "N"

ART III: TO BE COMPLETED WITH SPOUSE'S INFORMATION.

1-10-24 F 402-28-8552 Eva J.
 BIRTH DATE SEX SOCIAL SECURITY NO. FIRST NAME MIDDLE INIT. LAST NAME (IF DIFFERENT)

ART IV: TO BE COMPLETED WITH ELIGIBLE DEPENDENT'S INFORMATION.

ENTER ELIGIBLE DEPENDENT INFORMATION BELOW-USING THE COLUMN HEADINGS AND THE CODES/DEFINITIONS ON THE COVER SHEET. ENTER SCHOOL ATTENDED FOR FULL TIME STUDENTS OR APPROPRIATE QUALIFYING COMMENTS IN THE SPACE PROVIDED BELOW RIGHT.

BIRTH DATE	REL.	CLASS	SEX	SOCIAL SECURITY NO.	FIRST NAME	MIDDLE INIT.	LAST NAME (IF DIFFERENT)	COMMENTS
1-10-30-60	N	C	M	402-86-6432	Robert	M.		1.
2.								2.
3.								3.
4.								4.
5.								5.
6.								6.
7.								7.
8.								8.
9.								9.
10.								10.

I HAVE READ THE ATTACHED STATEMENT REGARDING ELIGIBLE DEPENDENTS. I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT QUESTIONS CONCERNING A PERSON'S ELIGIBILITY AS A DEPENDENT SHOULD BE REVIEWED WITH THE PERSONNEL DEPARTMENT

Robert M. Hogan 5-16-75 10-15-75
 EMPLOYEE SIGNATURE DATE PERSONNEL POINT DATE