DEPENDENT 3: _____ MALE/FEMALE: _____

RELATIONSHIP: (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2018? _____ DISABLED? (Y/N) _____

DID YOU PAY DAYCARE? (Y/N) _____ IF YES, HOW MUCH? _____

HEALTH INSURANCE? (Y/N) _____ INSURANCE COMPANY: _____

DEPENDENT 4: _____ MALE/FEMALE: _____

RELATIONSHIP: (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2018? _____ DISABLED? (Y/N) _____

DID YOU PAY DAYCARE? (Y/N) _____ IF YES, HOW MUCH? _____

HEALTH INSURANCE? (Y/N) _____ INSURANCE COMPANY: _____

DEPENDENT 5: _____ MALE/FEMALE: _____

RELATIONSHIP: (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2018? _____ DISABLED? (Y/N) _____

DID YOU PAY DAYCARE? (Y/N) _____ IF YES, HOW MUCH? _____

HEALTH INSURANCE? (Y/N) _____ INSURANCE COMPANY: _____

DEPENDENT 6: _____ MALE/FEMALE: _____

RELATIONSHIP: (I.E. CHILD, STEPCHILD, PARENT, ETC.): _____

SSN: _____ DOB: _____ AGE: _____

NUMBER OF MONTHS LIVED WITH YOU IN 2018? _____ DISABLED? (Y/N) _____

DID YOU PAY DAYCARE? (Y/N) _____ IF YES, HOW MUCH? _____

HEALTH INSURANCE? (Y/N) _____ INSURANCE COMPANY: _____