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**Other Coverage Questionnaire – Dependent Child(ren)**

#### Employer’s Name:

#### Employee’s Name:

#### Child’s Name:

**Child’s marital status:**  Single  Married

If married, spouse’s name:

If married, spouse’s date of birth:

If married, spouse’s employer’s name:

**Is the child attending school?**  Yes  No If yes, complete the school information below:

Name of School:

Type of School:  High School  College/Trade

Student Status:  Full-time  Part-time

Expected Graduation Date:

**Is the child covered under any of the following health plans?**

Other biological parent’s plan  Step parent’s plan  No other coverage

Medicare  Medicaid  Tricare

Child’s own employer plan  Child’s spouse’s plan  State plan/CHIP

**Is there a divorce decree involved?**  Yes  No (Attach Copy if applicable)

Spouse / other parents date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If this dependent has health coverage through another source, please complete the following information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Insured (Policy Holder) | Date of Birth of Policy Holder | Employer | Insurance Carrier | Effective date of Coverage | Med | Den | Vis |
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***To the Employee:***  I understand that falsifying employment status and/or coverages is fraud and could result in financial penalty, loss of coverage, and separation of employment.

Employee’s Signature Date

Child’s Signature (if age 18 or older) Date

**Logo

Description automatically generated with medium confidence**

**\*Dependent child’s employer must complete this page.**

**\*To the employer: Any person who with intent to fraud or facilitate a fraud or provide false information, may be guilty of insurance fraud.**

**Dependent child’s name**:

1. Do you offer insurance benefits/coverage to your employees?  Yes  No

2. Is the above-mentioned child (your employee) eligible for benefits/coverage?  Yes  No

3. If they are eligible for benefits/coverage, what is the first date eligible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What coverage(s) are he/she eligible for?  Medical/Drug  Dental  Vision

4. What coverage(s) did he/she elect?  Medical/Drug  Dental  Vision

5. If coverages were elected, what is the effective date of coverage under your plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name of Employer: |  |
| Employer’s Phone #: |  |
| Employer Representative Title: |  |
| Employer Representative Email: |  |
| Employer Representative Name (printed): |  |
| Employer Representative Name (signature): |  |
| Date: |  |
| Dependent child/your employee’s signature: |  |
| Date: |  |