

Dependent Coverage Add/Change Form



I. MEMBER INFORMATION

Name of Member (Last)	(First)	(M.I.)	/ /	- -
			Date of Birth	Social Security Number
Street Address ()				
	City	State	Zip Code	Telephone #
Local Number		Employer		

II. DEPENDENT INFORMATION

ADD / CHANGE DEPENDENT INFORMATION

Please include a copy of any court document, such as a divorce decree or QMCSO that pertains to medical coverage for your dependent(s).

	Dependent	Dependent	Dependent
Last Name			
First Name			
Date of Birth	/ /	/ /	/ /
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Member	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child
Social Security Number	- - - - -	- - - - -	- - - - -
Address (if different from member)			
Are you employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your employer offer insurance coverage? <i>If yes, complete Section III.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Are you enrolled or eligible to enroll in an eligible employer-sponsored health plan, other than a group health plan of a parent? <i>If yes, complete Section III</i>	<input type="checkbox"/> No. Check One <input type="checkbox"/> Yes. Complete Section III.	<input type="checkbox"/> No. Check One <input type="checkbox"/> Yes. Complete Section III.	<input type="checkbox"/> No. Check One <input type="checkbox"/> Yes. Complete Section III.

Other Insurance Verification Form



III. Other Insurance Coverage Information

Employer Name: _____

Phone Number (____) _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Hire Date: _____ Current Position: _____

My employer does not offer health insurance coverage at this time. (Skip to the bottom to sign and date)

Name of Other Insurance: _____

Address of Other Insurance: _____

City: _____ State: _____ Zip Code: _____

Phone Number of Other Insurance: (____) _____ Policy Number (as it appears on the card): _____

Group Number: _____ Effective Date: _____

Coverage Includes (check all that apply):

<input type="checkbox"/> Medical & Prescription Drug.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Vision.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Dental.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family

I hereby certify that all the information in this section is accurate and complete to the best of my knowledge. I hereby authorize my employer to release information regarding my employer's health insurance plan and my eligibility for coverage under that plan to the Fund. I understand this authorization remains in effect as long as I am eligible for benefits under the Fund. I understand the purpose and scope of this authorization is to allow the Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

I also understand that if my employment status or the availability for insurance coverage through my employment changes, it is my responsibility to notify the Fund office immediately.

Signature: _____ Date: _____