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	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Relationship to Member	☐ Dependent Child ☐ Step-Child ☐ Guardian Child	☐ Dependent Child ☐ Step-Child ☐ Guardian Child	☐ Dependent Child ☐ Step-Child ☐ Guardian Child
Social Security Number	____--____--____	____--____--____	____--____--____
Address (if different from member)			
Are you employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does your employer offer insurance coverage? *If yes, complete Section III.*	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ 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? *If yes, complete Section III*	**Check One** ☐ No. ☐ **Yes. Complete Section III.**	**Check One** ☐ No. ☐ **Yes. Complete Section III.**	**Check One** ☐ No. ☐ **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):

☐ Medical & Prescription Drug……☐ Employee Only………..☐ Family
☐ Vision……………………………..☐ Employee Only………..☐ Family
☐ Dental……………………………..☐ Employee Only………..☐ 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:** ________________________