Dependent Coverage Add/Change Form

PO Box 300019 Kansas City, MO 64130

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?	☐ 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?	**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.

X Member Signature: _____ **Date:** _____
(REQUIRED)

X Dependent Signature: _____ **Date:** _____
(REQUIRED)