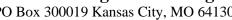
## **Dependent Coverage Add/Change Form** PO Box 300019 Kansas City, MO 64130





| I. MEMBER INFORMATION   |   |   |   |  |
|---|---|---|---|--|
|   |   |   |   |  |
| Name of Member (Last) (First  | st) (M.I.)  | Date of Birth   | Social Security Number  |  |
|   |   |   | ( )   |  |
| Street Address  | City Sta  | e Zip Code  | Telephone #   |  |
| Local Number  | Employer  |   |   |  |
|   | 1   |   |   |  |
| II. DEPENDENT INFORMATION   | ON  |   |   |  |
| □ 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         |   |   |   |  |
|   | depende   |   |   |  |
|   | Dependent   | Dependent   | Dependent   |  |
| Last Name   |   |   |   |  |
| First Name  |   |   |   |  |
| Date of Birth   |   |   |   |  |
| Sex   | □ Male □ Female   | ☐ Male ☐ Female   | ☐ Male ☐ Female   |  |
| Relationship to Member  | <ul><li>□ Dependent Child</li><li>□ Step-Child</li><li>□ Guardian Child</li></ul> | <ul><li>□ Dependent Child</li><li>□ Step-Child</li><li>□ Guardian Child</li></ul> | <ul><li>□ Dependent Child</li><li>□ Step-Child</li><li>□ Guardian Child</li></ul> |  |
| 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  | tion  |   |  |
|--|---|---|--|
|  |   |   |  |
| Employer Name:   |   |   |  |
| Phone Number ()  |   |   |  |
| Employer's Address:  |   |   |  |
| City:  | State:  | Zip Code:   |  |
| Hire Date:   | Current Position:   |   |  |
| ☐ My employer does not offer health in:  | surance 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):  | ☐ Vision  | □ Employee Only□ Family□ Employee Only□ Family□ Employee Only□ Family   |  |
| under that plan to the Fund. I understand to   | ion regarding my employer's health<br>this authorization remains in effect a<br>e of this authorization is to allow the | to the best of my knowledge. I hereby insurance plan and my eligibility for coverage is long as I am eligible for benefits under the Fund to verify with my employer whether I am |  |
| I also understand that if my employment st<br>is my responsibility to notify the Fund office |   | coverage through my employment changes, it  |  |
| X Member Signature:(REQUIRED)  |   | _ Date:   |  |
| X Dependent Signature:(REQUIRED)   |   | _ Date:   |  |